THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

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PRESIDENT O'HANLON GIVES AIMS OF ASSOCIATION

PERMIT me to welcome you to the deliberations of the twenty-fourth annual session of this association, and again to thank you for the honor you conferred upon me when you made me your president, for I consider the election to the presidency of this association the highest honor that can come to any one in our work. Since my election my moods have varied, like those, I dare say, of every one of my predecessors. At first, like them I am sure, I determined I would take time by the forelock and prepare this message at once, but alas, like most good intentions, my resolutions came to naught and days and weeks and months flew by without a line, until at last when delay could no longer be permitted, I cast about for a subject, and it seems to me that everything conceivable has been written upon by my worthy predecessors.

Upon opening my mail one morning I received several questionnaires asking for information: What salaries are you paying your employes up to and including the superintendent? How has prohibition affected your hospital? What is the effect of the late war upon medical and surgical practice in the hospitals, on the profession and upon you as a superintendent? Should the superintendent of nurses be under the superintendent of the hospital? Can you recommend a certain sanitarium in New York advertising through the southwest a sure cure for obesity? Should osteopaths be allowed to practice in the hospital? Should hospitals be obliged to employ registered pharmacists? From Porto Rico came a letter asking about a cure for diabetes, and this and a variety of other letters, brought forcibly to my attention the fact that we, as hospital administrators, live in a mass of questions, and it occurred to me that I might pass a few of them on to you. So if the fragmentary remarks I shall make to you must have a title, I think it might well be "The Great Question."

As I said, we hospital administrators live in the midst of a mass of questions. They rise and confront us on every hand. They grow up like thistles in the field,—questions social, economic, financial, nursing, medical, industrial and international. We walk in a forest of them, some tall as trees and seemingly as big in girth, while others form a jungle of little irritating problems that catch at us and tear us as we try to make our way. Everybody seems so busy asking questions that nobody seems to have time to answer them. One favorite way of trying to answer them is to send out a questionnaire; as if we had moved forward toward the answer to one question by raising forty more. Never mind whether anyone answers or not; send out the question, then feel that you have done something. The sign of the times seems to be a huge question mark.

That the development and extension of the interests of this association have been along lines mapped out for it in an attempt to answer the questions of its members is perfectly apparent to one who looks over the program of its earlier conferences. In the beginning there were most valuable contributions to the literature of hospital administration by the recognized pioneers in the field. Then came the committees with their report on some particularly difficult or obscure question; then as a solution for the various perplexities appeared the question box and answer which now is seen in such large letters as a part of our program in the form of round table conferences. As time passed and our work broad-

*Presidential address of George D. O'Hanlon, M.D., superintendent, Bellevue and Allied Hospitals, New York, N. Y., read before the twenty-fourth annual convention of the American Hospital Association, Atlantic City, N. J., September 25, 1922.

ened, in order to meet the ever increasing demand for varied information it was necessary to set apart a place on the program for groups doing a special piece of work. These groups express themselves to you from the program, each year increasing in number in the form of section meetings.

Welcomes Section on Trustees

The seventh, the trustees' section, appears for the first time this year, and it would seem there could be no greater contribution to our association than will come from the closer relationship with the governing bodies of all of our institutions. Do your trustees annoy you? Should we educate the board of trustees? How much should the board of trustees know about the hospital? These are questions I have heard propounded from the floor at more than one of the previous meetings of this association, and I must confess it was more or less of a shock to find some apparent concurrence from members to the thought that trustees should be kept in ignorance regarding anything pertaining to the work for which they are responsible, and in the performance of which we are their representatives. In my opinion the best way to educate a trustee is to bring him and his hospital into the personal or institutional membership of this association, and in behalf of the association I today officially welcome this new section to our body.

The growth in our membership has been slow and steady, but not in any way commensurate with the number of hospitals springing up throughout the United States and Canada. In Bulletin No. 3 for this year, the executive secretary presents some interesting data relating thereto, with helpful interpretive suggestions which I commend to your careful consideration. Some of our more conservative members have expressed apprehension lest the increasing number of state, or independent, hospital associations would detract from our parent organization, and ultimately bring about its dissolution. While as conservative as any, I feel no such apprehension; on the contrary, I believe the field is broad enough, and we as executives should be sufficiently expansive in our views, to welcome any group, be it geographical, denominational or otherwise.

The facilities for communication as between members and officers of this association are, as you know, practically restricted to the bulletins issued at irregular intervals by our very able executive secretary. While individually and collectively we, as members of this association, are under limited obligations to the owners and publishers of the hospital journals now in the field, the time must come when we shall have a publication of our own. The American Medical Association has its journal; the American Psychiatric Association has its journal; the American Occupational Therapy Association publishes *The Archives of Occupational Therapy;* the Canadian National Association of Trained Nurses has its official organ in *The Canadian Nurse;* the American Nurses Association publishes *The American Journal of Nursing;* social service also has its journal, so why not the American Hospital Association?

Members Guide the Policy

The executive secretary will tell you the trustees are exercising a progressively increasing degree of control and supervision over the activities of the association. It is becoming more and more, as it should be, your association, and I think it is not too much to state very positively and definitely that the association is not controlled by any group or clique. The policy shall be whatever you would like it to be, but you must not sit quietly back in your office chair, keeping your ideas and suggestions to yourself. Send them to the trustees, or the secretary. I am sure nearly every one here today has some thought of his or her own of what should be done at this meeting. The number passing on to the president those suggestions I assure you is surprisingly few.

To meet the criticism so often openly expressed of the association's method of electing its officers, your trustees are this year offering a new and, we trust, more satisfactory form. While the committee will present for your consideration definite nominees for the respective offices, any member or voting delegate may place in nomination from the floor, any person he may wish, or he may place upon his ballot the name of any person he may prefer.

I often wonder how many of us pause to consider how much has really been accomplished by and through the hospitals in this country during the last fifty years. Do you realize the oldest training school in the United States has not yet celebrated its fiftieth anniversary, and that when it was established, there were only 140 hospitals in this country, including institutions for the insane, while today there are over 7,000—an increase of 5,000 per cent? That the first ambulance service in the world connected with a general hospital was established in the city of New York in 1869? That the first school connected with a hospital for the practical training of midwives was opened in 1911, and today twenty-eight states have laws regulating their practice, thus officially recognizing them as a professional group? That hospital social service dates back only seventeen years, and how many of us have

yet to be convinced that our staff is not complete unless we have one or more social service workers upon it? Are we all awake to the value of prescribed occupation, and are we giving our patients the benefit of this therapeutic measure, or are we just quietly resting back deluding ourselves that it is a fad or passing fancy?

Hospitals as Centers of Health Education

Our hospitals should be centers of social service, especially in the way of hygienic instruction. In the matter of prevention, hospital officials have a large and inviting field of labor. We should take a lively interest in the matter of public education, because, to my mind, that lies very near to preventive work. Disease, pauperism, crime, the alcohol question, as these relate to our own locality, all come within the purview of the hospital administrator, and he should prepare himself by study, not only of the patients coming to his hospital, but of their antecedents and surroundings, their work, their recreations and habits, in order that he may speak with authority.

The after-care or follow-up of discharged patients is happily being undertaken by hospitals through auxiliaries, special agents and trained social workers. This work should be widely extended. We should take a lesson from Timon of Athens, who taught that

> "Tis not enough to help the feeble up but to support him after."

The hospital so situated that it maintains an out-patient service will find here a rich mine for exploitation, and one which will aid materially in bringing cases promptly under care, but by the same token will reduce the pressure for beds within the hospital. If the hospital administrator can engage in teaching of any kind he should take advantage of it. Nothing sharpens ones wits so much as contact with a critical audience. The hospital that is doing its full duty is in itself a place of education—training the recent graduate in medicine in the application of medical science, training nurses, attendants, social workers, dietitians, technicians—a real laboratory for the study of psychology. The hospital superintendent who does not see opportunities for work beyond the restricted horizon of his hospital enclosure is shortsighted, and misses his opportunities for the best work, and the board of managers or directors which does not encourage him in making the best use of such opportunities, does not appreciate the full value possible to the community in the institution which it supervises, nor the opportunity for making the hospital do its full duty.

This is the day when efficiency in all departments of human endeavor is preached. The man, the machine or the hospital which is not working to its full efficiency is a losing proposition. It may be difficult sometimes to make those who hold the control, who govern the expenditures, see that some of the best returns from hospital activities can often be found in fields which at first glance do not appear worth cultivating or which may seem too remote. No better method could, in my opinion, be devised for awakening public interest in or public support and sympathy for the work we are doing, than by showing the public that the officials and personnel of our hospitals have not only an interest in the welfare of the patients in the wards, but also in that of the people of the community, in their health, in their work, in their environment, in their cares and perplexities, in their social problems, and herein lies much of the value of the Hospital Day or Week.

Must Avoid Complacency

The opening sentence of one superintendent to the trustees of his hospital in his annual report begins with this sentence: "The besetting weakness of a hospital superintendent is the complacency with which, when rendering the annual account of his stewardship, he reviews the operations of his particular institution." Is it not possible that too often complacency is shown not only at the time of making our annual reports but is a continuous condition of mind with many of us throughout the entire year? Are we sufficiently "alert with noble discontent?" Are we not too sufficiently satisfied if our patients are comfortably housed in wards not too crowded, the routine of the day's work not interrupted by untoward incidents, and our income commensurate with our expenditure? Are we content with keeping up with the procession or are we ambitious to lead the van? Do we indeed keep up with the procession when we compare our work and results with what is being done in other general hospitals over the land?

"Faithful are the wounds of a friend"; remember please, should there be any querulous ones, my queries are not in the line of criticism. I do not place myself in the category of those who know a little more than you, but, on the contrary, much less than many. Neither do I propose to deny what I cannot see, nor deride that I have never felt. For more years than I care to remember I have watched the progress of general hospital administration, and have longed for the time when as a field of work for ambitious men and women it should come into its own. I believe the time is coming; it remains for us to hasten or hinder the day.

ASA S. BACON'S ADDRESS OF ACCEPTANCE OF THE OFFICE OF PRESIDENT

I CAN hardly express in words my appreciation of the honor you have bestowed upon me, but I can honestly say that if I have made any success as a hospital superintendent, it is due principally to my many years of activity as a member of the American Hospital Association.

When I first took up hospital work, nearly twenty-five years ago, I realized that to succeed, hospital workers must in some way get together for the exchange of ideas; therefore, as soon as I had the opportunity, I joined the American Hospital Association. I was not alone in this thought, for if you will notice our membership list from the beginning, you will see that it is composed of hospital workers whose institutions are the most progressive in the country. In order to do the greatest amount of good to the sick of our land, every hospital, no matter how large or how small, should become a member of our association for moral support and for our mutual benefit. Our association is not in business to make money. It is run on the same basis as our hospitals. The officers and directors give their time and labor without any remuneration. To the various committees we owe our gratitude for their services given free of charge, the only salaried officer being your executive secretary.

Asa S. Bacon, the new president.

We need your membership in order to carry on the program for the future. Where there is no growth and development, there is disintegration; therefore we must speed up our development.

I believe that every factor pertaining to hospitals should be studied and adjusted as rapidly as possible, and permanent bureaus established for all departments that are necessarily continuous. This should be done as quickly and as conservatively as conditions will permit.

We have created conditions in and around our association that make it compulsory for us to forge ahead in the interest of our hospitals.

From now on, we should be a fast-moving organization, always alert, taking advantage of every change in our laws, in hospital administration, in our medical and nursing schools, and instantly passing it on to our membership. Our guiding star is "higher standards in the care of the sick," to attain which we must be at all times a constructive organization.

I believe that if we can group all our interests into state organizations, which are under the direction of the parent organization, we can become the greatest factor in our government for the promotion of health to our people throughout the land. We can accomplish this when we hold in our files a complete membership of the hospitals of the two countries, thus working together as a unit for proper laws and standards in the care of the sick.

The American Hospital Association now seems destined to be a potent factor in the development of progressive and efficient hospital service to the public; therefore the management of the association now exercised by its trustees and officers becomes a most sacred trust.

As a great building reflects the ideals of its designers and builders, so our association represents the ideal of those who conduct its affairs; therefore your officers will continue to give serious thought to the future policies of our association.

"To some extent we barter our health for the other valuables—knowledge, skill and habits of utility to the community. At present we probably sell too much of health, but it would be equally unwise to sacrifice everything for health. It is better to be a Socrates with a headache than a perfectly healthy pig. There must be a compromise."—Thorndike.

FEEDING 2,000 IN THE CONGREGATE DINING ROOMS OF BOSTON STATE HOSPITAL

By ALBERT S. KENDALL, of Kendall & Taylor Co., Architects, Boston, Mass.

BOSTON State Hospital is an institution for the care of the insane, owned and supported by the commonwealth of Massachusetts. It cares for about 2,000 patients in two groups of buildings. These groups, called respectively the East Group for women and the West Group for men, are separated by about a quarter mile of open fields bisected by Morton street, one of the city's main highways to the southward. This separation into two groups is the result of a union of two city-owned institutions which were taken over and combined by the commonwealth some twelve years ago. It explains the necessity for the two congregate dining rooms illustrated herewith.

Another question will immediately suggest itself to anyone glancing over the plans: Why build the two dining rooms on different plans? The answer is—topography. The West Group dining room, which is for its site and surroundings ideal, could not be built upon the only available site at the East Group and secure that convenience for patients, central location and proximity to supplies which was considered vital to its success. On the site chosen there is a steep bank which brings the kitchen a full story below the level of the buildings from which the patients approach the dining room. It is desirable to have the kitchen on the ground floor for easy access for food, coal and the removal of garbage and ashes. The patients on the other hand should not have to go up or down stairs more than can be avoided to reach their dining room. Thus the two-story dining room was decided upon in spite of the difficulty in carrying prepared food up one story.

Built After Long Study

In studying the problem of adequately feeding 2,000 patients and employes the superintendent, Dr. James V. May, and the steward, Arthur E. Gilman, with the architect visited a number of institutions and made a prolonged study of plans and methods of service. Obviously the method of serving patients would in large measure determine the essential features of the plans.

The extremely interesting methods adopted by Dr. Harrington at Howard in Rhode Island gave valuable hints and were adopted with certain modifications. The West Group plan was inspired by a similar congregate dining room at Central Islip on Long Island, and we are indebted to Dr. G. A. Smith of that institution for some valuable hints.

The plans of the West Group are designed to be enlarged if needed by the addition of another group of three dining rooms at the other side of the kitchen building.

The plan at present consists of the kitchen, with scullery, storage, and refrigerating machine in the basement, three dining rooms each seating 200 patients, a central patients' serving room, a separate serving room for employes, a dining room for orderlies and attendants, and another for women nurses. Seven hundred and fifty persons are served in the dining rooms and 600 additional patients are served in the buildings to which they are confined. The disturbed patients and the infirm do not come to the dining rooms.

At the East Group 500 patients and 150 nurses are served in the building and about 200 patients are served outside the dining rooms.

Method of Food Service

The method of service is simple and effective. It succeeds in getting the food to the patients promptly and in a palatable condition. It arrives hot on the plate and with remarkably little fuss and confusion. The menus are of course simple, consisting of comparatively few dishes which greatly simplifies matters. The food is taken from the steamers, or kettles from the range, as the case may be, and transferred to covered containers on a wheel cart. The loaded cart is run into the central serving room where, if necessary, the food can be kept hot by placing it on the hot tops of the steam tables. The top surface of these tables is flat and without any wells or pans. It is seldom, however, that it is necessary to reheat any food, since covered containers have proved quite capable of retaining sufficient heat.

In the serving room the heated dishes are taken from the lower part of the steam tables or from the dish warmers and the cart continues its way to the far end of the living room. The patients meanwhile have come in, leaving their coats and hats in the coat room and taken their seats at the long tables, twelve patients at each table, six on each side. The food container and sufficient warm plates are removed and placed on the end of each table, the carriage returning to the serving room. The attendant serves the food from the container to the dishes which are passed down the

line by the two patients who sit in the seats next the ends. Each container of course holds just sufficient food for twelve patients. Second helpings when given are served from additional containers, kept warm in the serving room. Desserts are served in the same way after the empty containers have been collected. It is possible to serve a full dining room of 200 patients in five minutes in this manner.

At the East Group there are 500 patients in each dining room, but the same method is followed out. The containers are larger, for there are more patients at each table.

The dining rooms are very simple in construction and decoration, but they are high and airy and easy to clean. They can be and are flushed with a hose when necessary. Floors are fireproof, of concrete with terrazzo surface and wall base six inches high. The toilet rooms have a terrazzo dado six feet high. Walls are of brick plastered and the ceiling is plastered with the wooden roof trusses showing. The type of furnishings are shown in the pictures. The little entrance porches are about the only architectural touch in an otherwise rather severely utilitarian building.

The serving room, located at the junction of the three dining rooms is similar to the dining rooms in furnish. It contains the three plain top steam tables, three warming ovens, dressers for dishes and cutlery, three sinks and the coffee urns. The urns are of aluminum, are steam heated and are provided with a spray ring. The capacity is sixty gallons each. There is ample room for circulation and for the maneuvering of the three rather large food carriages, which move of course in three distinct lines of traffic.

Adjacent to the serving room and forming a part of the corridor connecting with the kitchen is the dish washing room where all the patients' dishes and silver are washed. The washer will cleanse and sterilize, if necessary, 6,000 dishes per hour, and the dishes coming out hot will dry themselves. Ample table space has been provided, as the dishes go through the washer faster than they can be returned to the tables or dish warmers by the help available.

Kitchen Floors of Red Tile

The kitchen floor is of heavy red quarry tile about 9 inches square and three quarters inch thick. This tile is laid with block joints about one-half inch wide. It is not possible to lay this sort of tile with a close joint and have it appear well, as the tile varies considerably in size. It is, in the opinion of the writers, however, the best floor for a large kitchen; cement floors deteriorate rapidly under the kettles and the lighter tiles will not stand the heavy traffic. Slate or bluestone is good but fails to equal the red tile in appearance.

The dado is five feet high and made of polished terrazzo. White Portland cement is used in the terrazzo which gives a cleaner appearance than the grey cement and takes a much higher polish. The floor is provided with several floor drains and can be cleaned with the hose with ease, as is quite evident in the picture. It was taken just after the floor had received a thorough hosing and the water is seen standing on the floor before it was mopped.

Hoods Not Used in Kitchen

One familiar with institution kitchens will notice the absence of any overhead piping or hoods. The smoke pipes from the ranges and broilers are taken down through the floor and thence to the flue directly back of the range. The vapor pipes from steamers, kettles and roasters are likewise taken down through the floor, carried along under the floor and up to the top of the chimneys. These pipes are six inches in diameter. The kitchen is high, twenty feet to the monitor, which can be opened or closed from the floor at will. There has never been any excess of steam in the room, or any condensation on the ceiling. Care is used not to allow live steam to escape into the room, and the hood has not yet been missed. Indeed its absence is greatly appreciated.

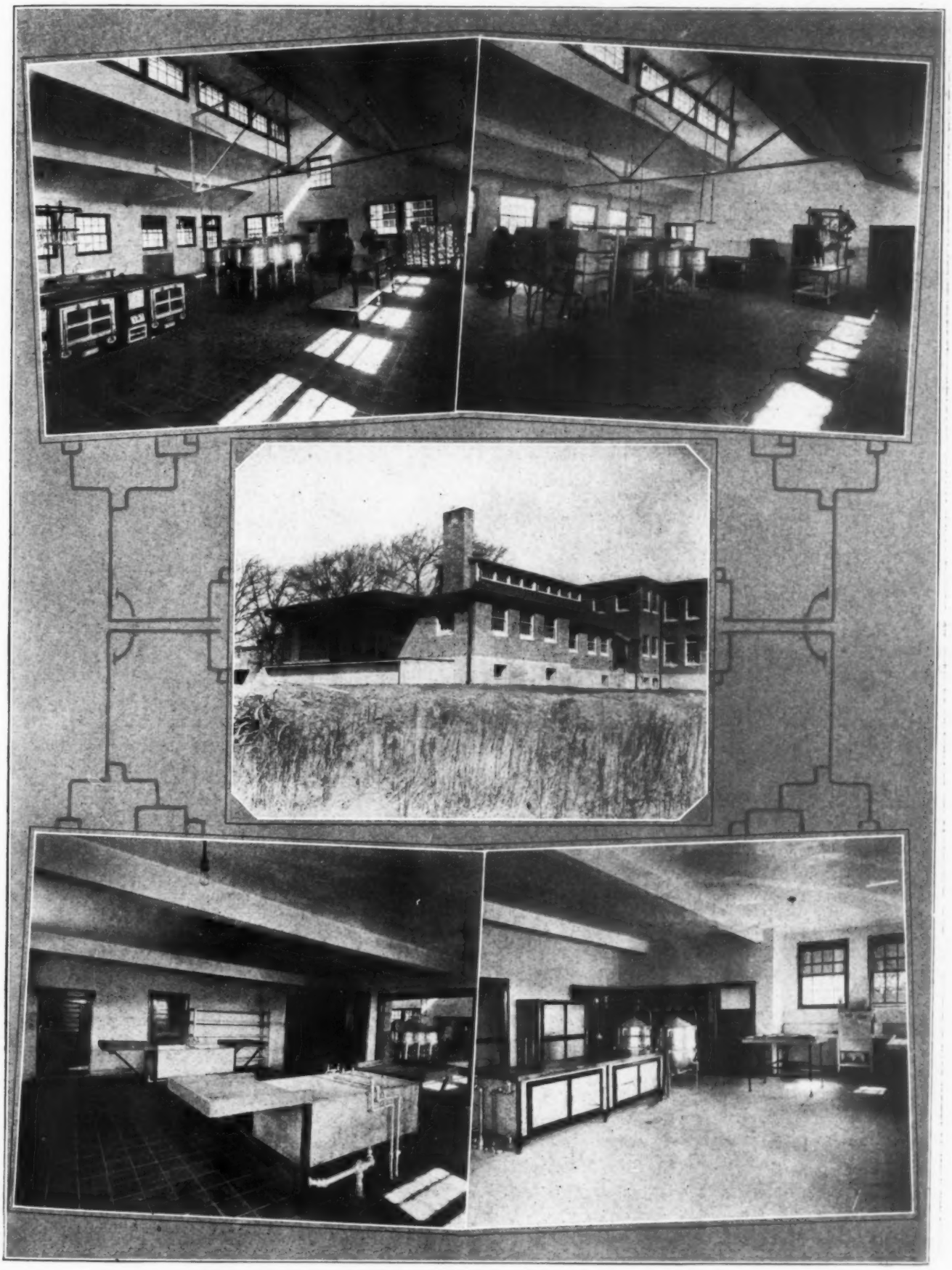
The advisability of leaving out the hood was considered at some length, and disaster was fully prophesied. When the fixtures were finally in place and connected, they were filled with water and steam turned on at every fixture. The vapor pipes easily handled all the steam. The only steam escaping into the room was when the covers were opened, and this, together with a blowoff from a safety valve on one kettle, did not cause enough to be disagreeable or to form any condensation on the ceiling. The essential points are large vapor pipe area, height of the kitchen and direct venting to open air at the top. Really much of the escape of steam in kitchens is due to carelessness in handling the fixtures.

All the kettles and roasters are aluminum and have connections for water, steam, return and drainage.

The drainage, except the toilet rooms, is connected through a cast iron grease extractor which contributes regularly to the income account by saving a considerable amount of valuable grease. The grease is drawn off regularly into a barrel without the necessity of skimming the grease trap, a distinctly disagreeable task.

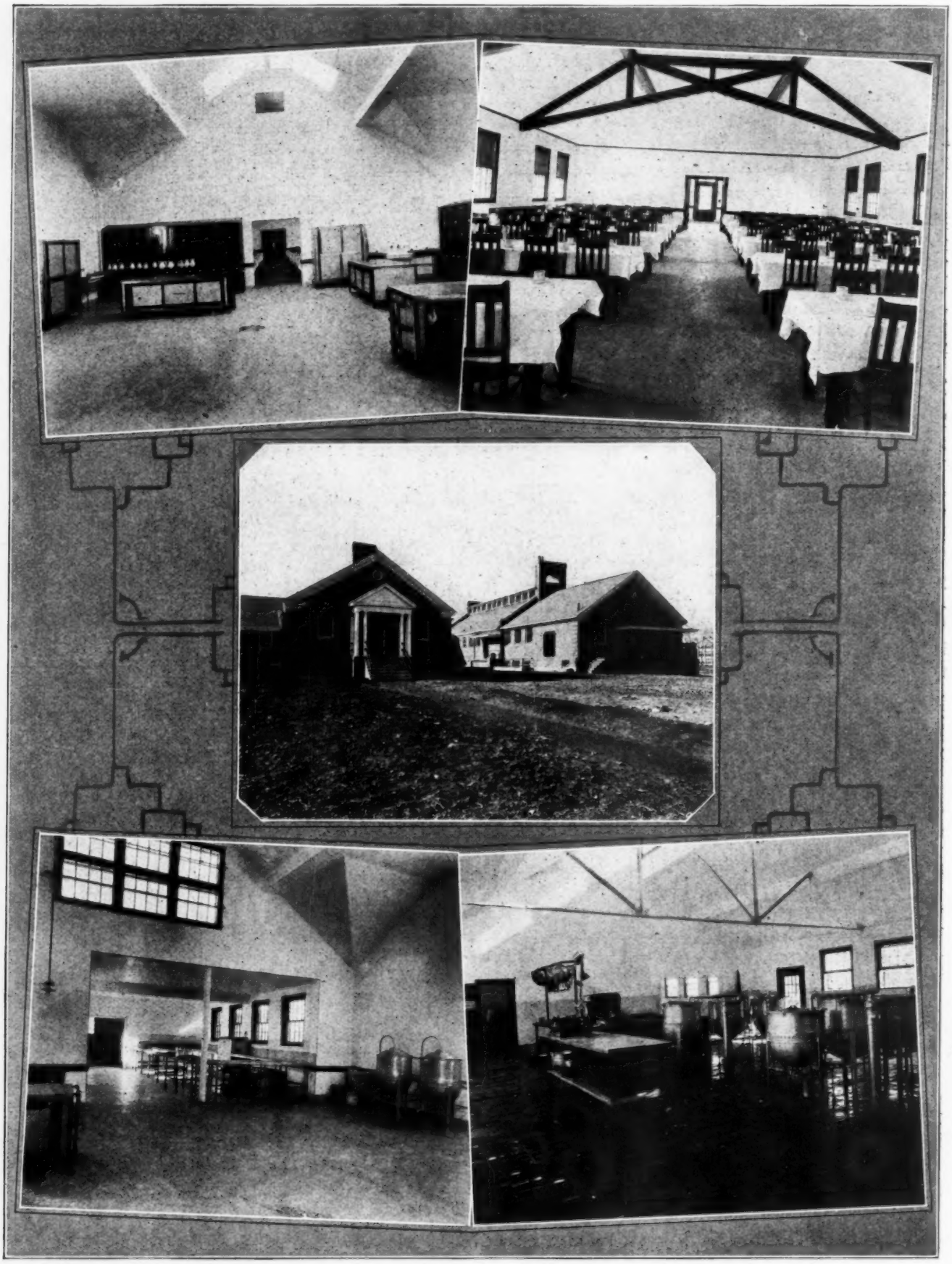
The side door in the kitchen is the delivery point for food which goes to the buildings for the disturbed or infirmary patients who cannot come to the dining rooms.

500 PATIENTS AND 150 NURSES ARE SERVED IN THE EAST GROUP



In the center is a view of the East Group kitchen wing from the rear. Above are two interiors of the kitchen; below are the scullery and pan room (left) and the second floor serving room for patients.

THE WEST GROUP OF BUILDINGS WHERE 750 MEN PATIENTS ARE FED



The exterior view shows the West Group kitchen wing on the right and the entrance to one of the patients' dining rooms on the left. Above are a patients' serving room and a patients' dining room. The main serving room and the kitchen are shown below.

At the rear of the kitchen is a pan room where the kitchen utensils and the food containers are cleaned and stacked when not in use. The elevator, a plunger type, opens at the rear of this room. This elevator is used to bring coal to the range, to transport prepared food from the scullery below and to remove ashes from the basement where they fall from the range gates.

On the other side is the cook's room and behind that the cook's refrigerators. The stairs, bread room and a large milk refrigerator complete the equipment of this building except for the basement.

There is no finished cellar under the dining rooms; simply space for piping and room to get at it.

The cellar under the kitchen is used for scullery and storage. Coal is stored in a pocket outside opening into the scullery. Ashes are dumped into a brick chamber directly from the range fires and removed at intervals. The dirty work of the kitchen is thus all confined to the basement, making it easy to keep the kitchen always clean and neat.

There is a five-ton automatic ammonia refrigerating plant in a room under the cook's room and cold boxes. The refrigeration is by direct expansion of ammonia gas with automatic control of temperatures. The boxes are constructed of four inch solid cork block erected as self sustaining partitions, and plastered on the inside with Portland cement and sand, and painted with enamel.

The floors are of terrazzo with terrazzo bases. The floors drain to the doors so that when hosed down the water runs to the floor drain in the cook's room.

Garbage is placed in underground garbage containers located in the platform at the rear of the kitchen and is removed to the piggery every day. The underside of the garbage containers is accessible through doors in the front wall of the platform, so that a hose stream can be turned in when necessary to clean out the garbage that through carelessness is inevitably spilled over the flanges.

The East Group kitchen is similar in arrangement to the West, and the general points of service are the same. This kitchen is located quite close to the storehouse and bakery, which serves the whole institution, so it differs in minor particulars. Refrigeration, for instance, is obtained by an extension of the brine circulation system which cools the general cold storage and ice plant location near by.

At the East Group the patients eat on the upper floor and their food is brought to them by means of two lifts from the first floor serving room. The ground floor dining rooms are used by nurses and on the other side by a number of male patients who are employed on the east side in the laundry, boiler house, bakery and about the grounds. These men also have a lounge and smoking room in connection with their dining room.

The two-story arrangement necessitates a duplication of the dish washing machines, and introduces other complications which prevent the plant from being quite as ideal as the West Group. The kitchen itself, however, is much the same and is run on the same plan as the other.

Fixtures for Kitchen

The following list of kitchen fixtures is complete for the West Group kitchen. The fixtures shown in the pictures do not quite tally with the list, as the installation is not yet complete in all details:

Kitchen—
- 12 ft. double face range, 6 fires, 6 covers.
- 36" coal broiler.
- double steel bake oven, each 48x34x76.
- 4 aluminum kettles 80 gal.
- 4 aluminum kettles 60 gal.
- 6 aluminum roasters 80 gal.
- 4 vegetable steamers, 3 compartment.
- 2 steel cooks tables 10′ x 3′ x 33″ with sink.
- 2 sauce pan racks 10 feet long.
- 2 10′ x 3′ x 33″ plain steel tables.
- 2 coffee urns 40 gal. aluminum.
- 1 mixing machine with all attachments.
- 1 meat slicer.
- 1 steam table, flat top 10′ x 3′.

Pan room—
- 2 pan sinks, metal with drainboards.
- racks for containers.

Scullery—
- 2 vegetable sinks, metal 3 x 3″ x 20″.
- 2 wooden tables 10′ x 3′.
- 1 vegetable peeler.
- 1 twin ice cream freezer with ice breaker.

Cook's room—
- 1 steel table 8′ x 3′ x 33″ with sinks.
- 1 dresser

Bread room—
- Bread racks, metal.
- Power bread slicer.

Serving room for patients—
- 3 steam tables 12′ x 3′ x 33″.
- 3 dish warmers 5′ x 2′ x 6′.
- 3 dressers.
- 2 coffee urns 60 gals. each.
- dish washer and tables.
- 3 sinks.

Serving room for nurses—
- 1 sink.

Steam table containing—
- 2 platters 14″.
- 2 gravy wells.
- 4 vegetable dishes.
- 4 jars 10½″.
- 2 coffee urns 30 gallons.
- 1 dish washer and tables.

ISSUES DIRECTORY OF SANATORIUMS

A directory of Canadian agencies for the diagnosis and treatment of tuberculosis has recently been compiled by the Canadian Association for the Prevention of Tuberculosis. It shows that there are in the provinces of Canada 4,057 beds available for tuberculous patients.

DIMENSIONS OF PRIVATE ROOMS

By HENRY C. WRIGHT, Hospital Consultant, New York, N. Y.

THE dimensions of private rooms are of great variety, not only as to relative square foot area but also as to the relation of their long to their short axis.

This paper is a brief study to determine if possible the minimum space requirements, and under what conditions it is advisable to exceed this minimum.

There are rooms in many different hospitals that have been in successful operation for many years whose dimensions do not exceed 8x11 feet, with the long axis at right angles to the corridor. In rooms of this size and orientation there can be but one window and the bed must be placed parallel and adjacent to the side wall.

Fig. 1

A patient in a bed pushed against the side wall must be served from one side of the bed or during service the bed must be pulled into the middle of the room, a thing difficult to do in a room but eight feet wide, owing to the interference of furniture. Moreover, a patient placed at right angles to the outer wall must so lie that either he cannot look out of the window or, if his head be reversed, he must face the window and cannot avoid its glaring light. There are rooms in successful operation in the Presbyterian Hospital, New York, of the dimensions given in the illustration, with the bed crosswise of the room.

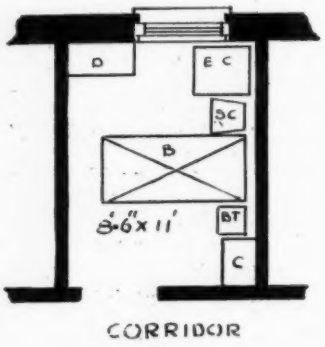


Fig. 2

D—Dresser and clothes press.
EC—Easy chair.
SC—Straight chair.
B—Bed.
BT—Bedside table.
C—Commode.

The square foot area of this second room is 93.5 but a little greater than the 8x11-foot room. It is a much more serviceable room from every standpoint. Though not wide enough to permit free passage at the foot of the bed, particularly for a wheel chair, nevertheless it is a reasonably serviceable room from the standpoint of the patient, the nurses and the doctors.

The two rooms illustrated above of nearly the same dimensions are each serviceable, one somewhat more so than the other. If ten square feet were to be added to either of these rooms, in which dimension would it be most advantageous? Let us assume that the general consensus of opinion is that a bed standing parallel with the corridor is the most desirable, will a room that permits of so placing the bed, namely one 8½x11 feet, gain more by adding 10 square feet to its width or to its length? This will be determined chiefly by two factors, the placing of the furniture and the services about the bed. The placing of the furniture is also illustrated as in Fig. 2.

The furniture, as indicated, consists of a bedside table, a straight chair, an easy chair, a dresser and clothes press combined and a commode. There is free space about the side of the bed. It would be advisable to have a bedside table on either side of the bed. This would require greater length in the room, but the cramped space at the foot of the bed probably hinders service much more than the lack of an additional bedside table. Greater ease of service is of more importance than furniture in addition to that indicated. Thus if the room were to be made 9½x11 feet it would be found more serviceable than were it made 8½x12½ feet. A room 9½ feet in width allows three-foot free space at the foot of the bed if the head of the bed is shoved tight against the wall; if, however, it is pulled away a few inches, as it should be, the space at the foot will be about 2½ feet. This is just sufficient space to permit two persons to pass and sufficient through which to roll a wheel chair. A three-foot free space at the foot of the bed is necessary for easy work about the bed. Thus a room should be made 10 feet in width before it is lengthened beyond 11 feet on its long axis.

Which Dimension to Increase

Assuming that in our calculation we have arrived at a room 10x11 feet, with its long axis at right angles to the corridor, and that the finances of the proposed hospital are such that a somewhat larger room can be provided, to which dimension shall the extra space be added?

The size of the room will be gauged primarily by two factors: first, the service that is to be rendered to the patient; second, the comfort and general well being of the patient. How big a free floor space is needed for service to the patient? These services may be listed as follows

so far as they relate themselves to floor space: (1) Bringing a wheel stretcher into the room and running it alongside the bed; (2) Turning the bed about with the purpose of taking it out of the room; (3) A service to the patient which requires two persons, one on either side of the bed; (4) An examination of the patient by an attending physician with possibly two assistants.

A space of three feet at the foot of the bed, three feet clear on the side of the bed toward the window and four feet clear on the side toward the door will permit all of the foregoing services to be carried on with comparative ease. Two feet must be allowed for furniture against the outer end of the room. Other necessary furniture can be placed against the wall toward which the bed heads. With a 3-foot 6-inch bed the lengthwise space required would be $2+3+3\frac{1}{2}+4=12\frac{1}{2}$ feet with a width of $\frac{1}{2}+6\frac{1}{2}+3=10$ feet. If this area 10x12½ feet be clear of a closet or a lavatory it is a space sufficiently large in which to minister easily to the patient.

Now as to the comfort and general welfare of the patient. This is a factor hard to measure. A person accustomed to a small bedroom at home will be content with a small one in a hospital. On the other hand a person who has had a large bedroom in which to move about will feel somewhat cramped in a hospital room 10x12½ feet. Moreover a patient who has had the privilege of a large bedroom will feel more at home if a little furniture in addition to the bare necessities be in his hospital room. What additional space should be added for this factor of the patient's comfort and to which dimensions should it be added?

Increasing a room in width by one foot, from 10 to 11 feet, does not provide space for additional furniture but does push the opposing wall somewhat further away from the patient and gives him a sense of space. If the width be increased to 12 feet furniture can be placed along both side walls. It requires less floor area to lengthen the room by one foot than to widen it by the same amount. Thus it will be more economical to extend the length from 12½ to 13½ feet or to 14 feet than to widen the room from 10 to 11 feet. Lengthening the room provides space for the additional furniture. But all the furniture any patient or his friends should be able to use, except a couch, can be placed readily in a room 10x13 feet.

Some Typical Up-to-Date Rooms

If funds are ample a room larger than 10x13 feet is advisable from the standpoint of the general welfare of the patient. The following are the room sizes in a few well known hospitals having comparatively recently constructed buildings:

Henry Ford, Detroit, Mich.	9'10"x16'
Mt. Sinai, Cleveland, Ohio	10'x14'
Robert Packer, Sayre, Pa.	11'-1"x12'-6"
Elizabeth Steel Magee, Pittsburgh, Pa.	10'-8"x14'
Carson Peck, Brooklyn, N. Y.	11'x13'-9"
Brooklyn Hospital, Brooklyn, N. Y.	13'x13'
Massachusetts General Hospital, Boston	11'-3"x19'-2"
Mount Sinai, New York, N. Y.	11'x15' and 16'
Royal Victoria Ross Pavilion, Montreal, Quebec	13'x16'
James Buchanan Brady, Johns Hopkins, Baltimore, Md.	10'-1"x16'

It will be noted that the width of these rooms ranges from 9 feet 10 inches to 13 feet and the length from 12 feet 6 inches to 19 feet.

The Henry Ford Hospital received a large amount of study particularly from the standpoint of producing the most serviceable yet economical room unit. It adopted a room width of 9 feet 10 inches but put an unusual amount of space in the length of the room, viz. 16 feet. This is clear space without deductions for closets, lavatories, etc. Moreover, in the Ford Hospital the bed, which is parallel to the corridor, is about five feet from the rear of the room giving a large amount of space between the bed and the window. This is the reverse of the usual custom of placing beds. More frequently the bed is so placed that the larger portion of free space is between the bed and the inner end of the room. This places the working space where it can be reached by the fewest steps from the corridor. Owing to the location of the bathroom door (each room has a private bath), which is at the head of the bed in the Ford rooms, the free space beyond the bed becomes largely the working space.

The working space in the rooms of the private pavilion of the Massachusetts General Hospital is at the inner end of the room. The rooms are 19 feet long, and the bed is about 4 feet to 6 feet from the outer end, leaving a clear space of 10 feet to 12 feet between the inner wall and the bed. The bathroom door, however, is entered from the inner space; thus it is not necessary to pass the bed to reach it as in the Ford rooms. If a hospital has funds sufficient and wishes to build very large rooms like those in the Massachusetts General it would be well also to follow this scheme of locating the bed.

Judging by the experience of hospitals generally there is little occasion to make a room wider than 11 feet or longer than 16 feet.

The foregoing comments have been made on the type of room most generally used. It seldom has more than one window. In some of the old hospitals rooms were made with the long axis paral-

lel with the corridor. Present day practice with very few exceptions runs the long axis at right angles with the corridor. Thus the narrow dimension abutting the outer wall permits but one window.

In the Presbyterian Hospital, New York, a hospital plant which is soon to be abandoned because it is inadequate, are a few rooms with the long dimensions parallel with the corridor and with two windows. These are the most cheerful rooms in the hospital. They are flooded with light, and the nurses feel these rooms are the best in the hospital from the standpoint of ease of service and work. A room of 12 feet, with its long axis parallel with the corridor, can have two good-sized windows. It has more free, utilizable floor space than a much larger room with its long axis at right angles to the corridor. There is no question that a room with two windows provides very much better ventilation than can be secured with one. With two windows one can always be left open without a draught on the patient.

A room of this type accommodates furniture better than the usual type of room. Roosevelt Hospital, New York, has many rooms 11x13 feet with the long axis parallel with the corridor. In these rooms are the following pieces of furniture: bed, dressing table, three straight chairs, one easy chair, couch, commode, clothes press, screen, invalid table. A hospital room seldom has so much furniture. This room though only 11x13 feet contains not only the foregoing pieces but in addition has abundance of free space for service. A room of these dimensions with the long axis at right angles to the corridor could not accommodate so many pieces of furniture and have remaining ample service space.

The private pavilion of the New York Hospital was built about twenty years ago. Most of its rooms are 12 feet parallel with the corridor and 14 feet in depth. Each of these rooms has two windows. The 12-foot dimension is ample and the 14-foot depth is in excess of need, especially if a toilet and closet are provided adjoining the room. Under these conditions a room 11 feet in depth would be sufficient. A room 12x12 feet would appear to be generous in proportions and would permit the two windows which are highly desirable.

A hospital with rooms arranged as above indicated would cost slightly more than one with rooms having the long axis at right angles to the corridor, since this arrangement would require some additional outer wall. The hospital would be longer and narrower, a form not well adapted to congested city blocks. But where ground space is ample a little extra expenditure will greatly improve a hospital by providing rooms with the long axis parallel with the corridor and with two windows. This type may be illustrated by the following diagram:

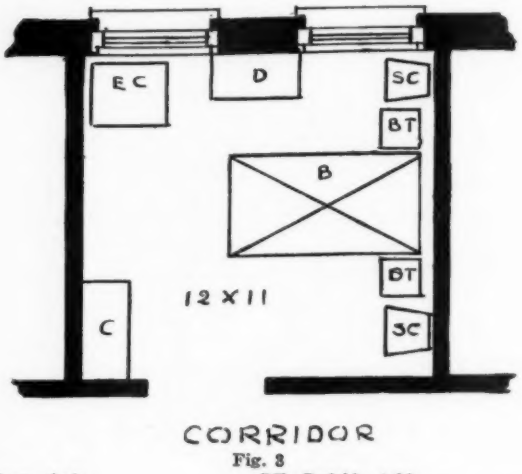


Fig. 3

EC—Easy chair. BT—Bedside table.
D—Dresser. C—Commode and clothes press.
ST—Straight chair. B—Bed.

If a toilet or bathroom and closet be provided for the room, the commode-clothes press would not be needed, resulting in additional free floor space.

RESERVE OFFICERS PLAN TO ORGANIZE NATIONAL MEDICAL SECTION

Permanent organization of a Medical Section of a National Reserve Officers Association will probably be effected this month at the national convention of the American Legion in New Orleans, it is announced.

During a recent encampment of the medical, dental, veterinary and medical administrative officers of the U. S. Medical Department Reserve Corps, 4th Corps Area, at Camp McClellan, Alabama, a temporary medical section was organized. Lieut. Col. Hardie R. Hays of Jackson, Miss. was named acting president and Maj. L. H. Webb, M.O.R.C., of New Orleans, acting secretary.

The following resolutions were passed by this organization:

"We, the medical, dental, veterinary, medical administrative officers of the Medical Department Reserve Corps, U. S. Army, of the Fourth Corps Area on active duty at Camp McClellan, Alabama, July 12 to 26, 1922, for the purpose of field training, being in meeting assembled and desiring to express our appreciation for the training and courtesy shown, be it resolved:

"1st—That we tender to Surgeon General and subordinates, to the Commandant Organized Reserve Corps, Camp McClellan, and subordinates, particularly Camp Surgeon and his staff of trained instructors, our sincere appreciation and thanks for the competent manner in which the technical instruction was given and courtesies shown.

"2nd—That we go on record as endorsing this plan of training for medical officers and hope that steps will be taken to procure the necessary funds to extend training in the future to a larger number.

"3rd—That we are unanimously opposed to the initial appointment of officers in the Medical Reserve Corps above the grade of first lieutenant, who were not on active duty during the World War.

"4th—That we further oppose any policy that places restrictions such as age, etc., or attendance at camp and any other restrictions of medical officers' promotions which are not placed on promotions of reserve officers in the line. Attention is respectfully invited to the fact that medical officers are in civilian life practicing every day their branches, and those officers of the non-technical branches are not practicing the form of duty upon which they will be called to function in time of war.

"5th—That copies of these resolutions be submitted to the Surgeon General (through Camp Surgeon) and Camp Commandant, Camp McClellan, Alabama, also that copy be furnished the Journal of the American Medical Surgeons, THE MODERN HOSPITAL, American Pharmaceutical Journal, National Dental Journal, Military Dental Journal and American Veterinary Journal.

"Committee:

L. H. WEBB, Major, M.O.R.C., Secretary, New Orleans, La.
F. M. HARBIN, Major, M.O.R.C., Columbia, S. C.
F. M. BOYETTE, Captain, M.O.R.C., Oneida, Tenn.
L. H. BREVARD, 1st Lt., M.O.R.C., Hernando, Miss.

THE REAL SIGNIFICANCE OF THE DISPENSARY IN HOSPITAL PRACTICE

By SAMUEL W. LAMBERT, M.D., Chief Attending Physician, St. Luke's Hospital, New York.

IN CONSIDERING the development of a hospital service the controlling radical principle to be recognized and carried out in all its details is the fact that the whole hospital in all its medical functions is a single institution for the treatment of the sick and injured. The modern hospital reflects the growth of medical science during the past fifty years and as each new and epoch-making discovery has been announced, the hospital has been compelled to add a new department to its growing activities. Any hospital could be considered in the first rank, in the seventies and eighties of the nineteenth century, which conducted a dispensary, the ward service and a laboratory of pathology, while its minimum amount of chemistry and clinical microscopy was done at a table in the laboratory.

The complete institution today also must have at least a laboratory for bacteriology and serology, another for chemistry and another for radiography, to say nothing of the new methods of investigating cardiac diseases. In addition, the extension of the rational care of the sick has introduced the great advances in philanthropy which are grouped together under the auxiliary work known as social service. These newer additions to an up-to-date hospital have increased not only the power to diagnosticate disease, but also the facilities for treatment and extensive plants for hydrotherapy, thermotherapy, radiotherapy, electrotherapy and mechanotherapy are coming into greater use every year. The latest development has been the discovery of the dispensary and of its real significance in hospital practice. The out-patient department of the well regulated hospital has overshadowed and outgrown in importance the service in the wards. The out-patient department is no longer a neglected annex from which the transfer to the wards of a patient sick enough to go to bed means a complete change of doctors and a new start in the treatment of his disease.

Personal Physician to Sick Poor

The properly run out-patient service should include the admission department to the ward service for all cases; it should be also the accident ward for ambulatory and for ambulance cases; it should be the department where all cases apply first for treatment and where the largest number should continue to be treated in daily or weekly office visits with no question of such cases entering the bed service in the wards; it should be the medical adviser of all cases discharged from the wards during convalescence and in this way carry on the after care or follow-up system which has become such an important element in the tabulating of statistics, especially in post-operative surgical work.

Such a dispensary service will be forced by its contact with the wards to give careful attention to all its cases in the matter of physical examination and of treatment, both of which under the older regime were sometimes neglected until the dispensary became a real abuse. It will also force the ward services of the hospital to recognize the need and provide the beds to take care of those cases requiring hospital care among the patients suffering from diseases of the organs of special sense and of the nervous system. Such a dispensary will offer care and treatment to special groups of cases such as those suffering from heart disease, from diabetes or from tuberculosis. In this way the dispensary acts for the sick poor as a personal physician. In most cases the ward and the treatment of the disease in bed is only an incident in the course of a chronic illness and a temporary condition while the patients look to the out-patient department for the treatment of lesser ailments and for their ordinary and daily medical advice.

Very few hospitals, if any, have reached a development which cannot be further improved but some are working out their problems with an earnest will to do the best that can be done with the structural difficulties which old buildings planned for the older methods of administration force upon them. There still exist hospitals with no out-patient service at all and there are still in New York dispensaries with no hospital affiliations. Such anomalous conditions are the inheritance from the time when the interrelation of a hospital and a dispensary was not appreciated.

The discovery of the dispensary has meant as much to the professional staff as it has to the office of administration. The medical man who has limited his work to a ward service will find in the out-patient service cases which present the early symptoms of serious diseases; he will find patients who complain seemingly of lesser ailments and who present the problem of being able to work on a part-time job if they are helped. Both in the dispensary and in the wards the cur-

ing of disease is the important part of the work; in the dispensary the problem of keeping the handicapped at home, out of bed and doing the maximum amount of work of which they are capable is substituted for the duty of the ward to make the incurable and the dying as comfortable as possible. In no class of cases is the cooperation of dispensary and ward so well exemplified as in those suffering from chronic heart disease. Since the special class for heart cases has been established at the out-patient department of St. Luke's, these patients return for a course of treatment in bed at less frequent and at longer intervals. For the younger physicians the study and care of ailments of temporary duration and of minor severity can be carried on in the dispensary and will round out their experience and complete their education after they have finished their intern service.

The organization of the professional staff to attend to all the duties of indoor and out-of-door patients requires a readjustment of the present conditions existing in hospitals under the older plan. Each division of the hospital wards should have connected with it a service in the out-patient department on which attendance should be required at least for three days in the week. The physicians on duty in the wards should visit the dispensary at fixed and regular times and those whose chief work for the institution is in the dispensary should also have not only the privilege but the right to visit the wards. In no other way can the patients be cared for professionally by a single responsibility when they are transferred from ward to dispensary or vice versa. All the physicians should be on a full time service, by which is meant not the full time panacea which would engraft a monastic seclusion on hospital physicians and which is being supported under contract by large foundations and carried on in a few schools and hospitals. The whole staff of hospital physicians should be on a full time or continuous service except for necessary vacations, and at least with the possible exception only of the lower grades of assistants, all hospital physicians should serve actively in only one institution of the same character.

Organization at St. Luke's

In St. Luke's Hospital much has been done to bring the out-patient service and the wards into a close relationship. The professional staff is on continuous service and the laboratories have representatives on the clinical staff. The present arrangement can be further improved upon without doubt, and plans for the future will perfect some of the present and necessary shortcomings. It is impossible at St. Luke's, for instance, to bring about a single office of admission to dispensary and to wards, because the buildings were designed before the importance of the dispensary in the hospital organization was at all appreciated. The patients have been brought under a single professional responsibility and this chief benefit of the new ideas has been secured.

The staff is one of pyramided responsibility. There is one attending physician, who is also director of the out-patient department, and two associates, one of whom is clinical pathologist and in charge of the chemical department of the laboratories. Each of these latter then has equal right to take charge of the ward service during the vacations of his colleague. There are two assistants, one of whom is chief of clinic in the dispensary service assigned to the division and both of whom have rights to visit the wards and to oversee such educational groups of medical students as may be assigned to the division and prepare those students to accompany the associates or attending physician on formal rounds. There are an indeterminate number of assistants who work in the dispensary, most of whom are former interns of the hospital. One of these has ward rights and is in charge of the electrocardiograph, and all have the privilege of visiting the wards, especially to follow the cases sent in from their own rooms in the dispensary. And finally there is a rotating house staff of four, serving for periods of six months each, in several grades, the first in the laboratories and the last as house physician.

The two distinctive features of conducting the service are, first, general ward rounds on one morning of the week when the whole staff including the assistants from the dispensary makes a thorough clinical inspection of the wards and discusses the medical happenings of the previous week. The second and more important innovation is a weekly visit by the director, accompanied by the whole staff including the interns to the dispensary. At these visits, new cases are diagnosticated, old cases, both those formerly in the wards and also those in the dispensary, are reexamined and given the advantages of a medical consultation. The cardiac clinic meets in the dispensary twice a week, at times separate from those devoted to the general cases, and the physicians from the ward service attend these heart clinics for consultation whenever possible. This resumé of the medical organization of Division B at St. Luke's is presented not as a perfect scheme of service, but as an example of a developing and growing system which it is hoped will be still further improved in the future.

THE RECONSTRUCTION HOSPITAL: A HERITAGE FROM THE WORLD WAR

By ROBERT STUART, Superintendent, The Reconstruction Hospital, New York, N. Y.

AN OUTSTANDING advance in the solution of the problem of the rehabilitation of injured industrial employes is seen in The Reconstruction Hospital at Central Park West and 100th Street, New York.

The conception of this hospital arose from the work of the Clinic for Functional Re-education, which was established by a philanthropic founder for war service and opened July 15, 1918. The methods employed at this clinic were copied from the British, French and Canadian reconstruction hospitals, and were found so successful through a period of two years' trial that it was resolved to make them permanently available for industrial accident patients.

To this end and to enable great expansion of the work a consolidation was effected with the Demilt Dispensary (founded 1851) and the Park Hospital (founded 1902), the latter institution having also done excellent war service while known as the Red Cross Hospital. Thus a notable consolidation of three important medical institutions was accomplished through reincorporation with the new title, "The Reconstruction Hospital." With this hospital is affiliated by special resolution, the Institute for Crippled and Disabled Men. The facilities of the hospital are utilized weekly by Cornell University Medical College in teaching students.

Already Outgrown Its Quarters

The Park Hospital was the fortunate possessor of a small but excellent hospital building and of a large vacant lot adjoining it in one of the most desirable locations of the city, facing Central Park. To this hospital building the original Clinic for Re-education was moved in April, 1921, and the work of The Reconstruction Hospital has so far outgrown its quarters that a large addition has been planned and erection is under way.

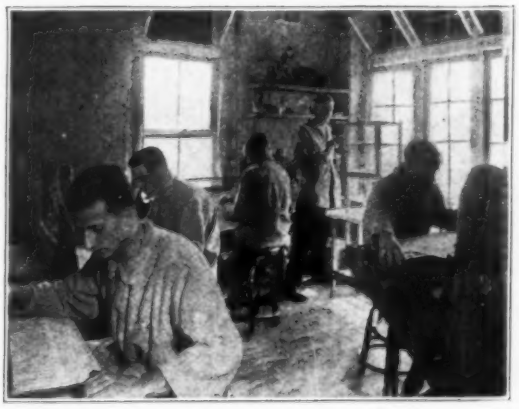
The present officers of The Reconstruction Hospital are: W. Gilman Thompson, M.D., president; Allen Wardwell, chairman, board of directors; John A. Hartwell, M.D., vice-president; Giraud F. Thomson, vice-president; Edward M. Townsend, treasurer; Elwyn W. Poor, secretary; and Robert Stuart, superintendent and assistant to the president.

The Reconstruction Hospital is maintained by a volunteer board of directors and operated by a volunteer board of visiting surgeons and physicians.

Disability is rated when the patient enters and leaves the institution; stated reports are furnished of the patient's condition at regular intervals, and companies may send their own inspectors at any time for report on special cases if desired.

For Accidents and Occupation Diseases

The hospital is specialized primarily for the treatment of industrial accidents and occupation diseases. The ordinary surgical work which can be dealt with in general hospitals is not included; in other words, The Reconstruction Hospital specializes in the treatment of fractures, burns, dislocations, sprains, hernia, nerve and muscle injuries, etc., but other cases not immediately due to injury, such as appendicitis, tumors, etc., are referred to general hospitals. Occupation diseases, particularly poisons acquired in the chemical trades, occupation neuroses, etc., are in-



Weaving

Electrotherapy

cluded in the scope of the work of the hospital.

Patients receive treatment by means of specially designed apparatus and equipment. The hospital maintains a corps of operators trained in the use of these appliances, many of whom have had three years' experience in the institution, treating under the surgeons' direction the maimed soldiers and sailors of the war. Particular study is made of diagnoses before treatment is given, and whenever necessary, a patient is examined by the consulting specialists together with the visiting staff. Thus the indications for the proper treatment are determined without loss of time.

The essential feature of the whole plan of The Reconstruction Hospital is to combine all the different procedures of operative and postoperative treatment in a complete logical sequence. Many

Basketry

of the general hospitals afford facilities for individual features of treatment, but The Reconstruction Hospital has grouped all these features with an increasing success during the four years of its experience.

Aims to Prevent Dependency

The primary object of The Reconstruction Hospital is to put the industrial employe, injured through accident, back on the job in the shortest possible time and to prevent the seriously injured man from ever lapsing into the attitude of the hopeless cripple, who so often becomes wholly dependent or a beggar. To this end, he may enter the hospital immediately after injury to receive first aid treatment, subsequent restorative operation when necessary, and continued after-treatment by means of physiotherapy (baths, electricity, hot air baking, massage, special exercises, etc.). While still in bed, occupational therapy is begun, to be continued when the patient is up and about, so that although still disabled, he may make articles of substantial value which are sold for his benefit. Thus long before he is able to return to the factory or workshop, he may be earning for his family and himself. When finally discharged from the need of further surgical care, he is referred to the Institute for Crippled and Disabled Men, where he may learn a new trade if unfit for his original one, and, in any event, is aided through the special employment bureau to obtain a remunerative job.

Since July, 1918, no less than 4,041 patients have been admitted; 782 operations performed; 238,078 individual treatments given in the various branches of physiotherapy and 8,113 x-ray pictures taken.

Patients have been received from eight different departments of the federal government, from state and city departments, in addition to those referred direct from a large number of industrial concerns, both local and at considerable distances from New York. The Erie, the Pennsylvania, the New York Central, the Ontario & Western and other railroads have made extensive use of The Reconstruction Hospital in cases requiring restoration of function.

While The Reconstruction Hospital aims to serve the woman worker as well as the man, lack of space at the present time prevents handling other than woman ambulant cases, clinics for which are conducted three times a week.

The hospital has most extensive plans for making studies of occupational diseases, publishing researches in new surgical methods and training doctors and nurses for special services in industrial medicine and surgery.

Being the pioneer hospital of its kind in the country, The Reconstruction Hospital feels the responsibility for leadership in this practically untilled field of endeavor and is making every effort to shoulder its responsibility. If its past record is any indication of its future usefulness, it is safe to prophesy that this most pressing industrial problem is in the course of ultimate solution.

Visitors are welcomed at all times, and those on whom responsibility for the proper care of injured persons lies, such as railroad officials, corporation doctors, insurance company claim agents, etc., are being cordially invited to visit the hospital for personal observation of the scope and atmosphere of the entire institution. A booklet of information has been prepared which the superintendent will forward to all inquirers.

MEMORIAL TO SANATORIUM HEAD

As a memorial to the late Dr. B. L. Taliaferro, superintendent of Catawba Sanatorium, Virginia, the patients at Catawba have decided to add a Taliaferro Memorial Fund to the Tuberculosis Foundation of Virginia. The fund will provide a free bed at the sanatorium. The Virginia Tuberculosis Foundation provides funds for tuberculosis patients unable to afford sanatorium care.

HOSPITAL LINEN

By L. H. BURLINGHAM, Superintendent, Barnes Hospital, St. Louis, Mo.

IN DISCUSSING hospital linen the writer has in mind household linen used in the care of patients, such as sheets, pillow cases, spreads, washcloths, towels, tray covers, stand covers, bureau and chiffonier scarfs, gowns; materials used on dining tables, such as table cloths and napkins; certain clothing worn by employes, such as uniforms, gowns, aprons and personal apparel; in fact everything that goes to the laundry except blankets.

Some Hints in Purchasing

Purchase of hospital linen should follow the procedure usual for all hospital supplies, that is, by competitive bids. Occasionally a considerable saving can be made by speculating for a long period in advance. It is always wise to get information from an unprejudiced person (usually one not interested in making the sale), but even then in the long run it is safer and more conservative to cover one's wants for only three to four months, never more than six months. The buyer should be sure that competitors are bidding on precisely the same goods, and if there is any question should demand samples, count threads and obtain the weight of the goods per yard (after washing if starch is used as a sizing). It goes without saying that unless an article has been standardized the head of the department where the article is to be used first should be consulted, as in this way improvements can be made and a greater degree of satisfaction obtained. It is often wise to have a sample article or piece of goods passed through the laundry several times in quick succession to ascertain how well the material will stand laundering and how great is the shrinkage.

Also one should bear in mind that while quality must always be considered, too fine quality, as in towels, makes for rapid disappearance. Linen disappears in many ways, some of which are obviously theft, but it is often difficult to lay a finger on the exact method of their departure. Sheets and pillow cases do not seem so likely to disappear, so a standard brand which will wear well is best. In wash cloths, the best buy is the most reasonably priced one that is satisfactory, as they seem to disappear more rapidly than any other article of linen.

Even a fairly small hospital can keep a small sewing-room supplied with mending, and on occasion many articles can be made up more cheaply than they can be bought. This can be best determined by a study of costs of labor and material. Happy is that hospital, the linen needs of which are cared for in whole or in part by some sewing organization, enabling money that would be spent thus to be turned to other hospital needs. While speculation is not advisable there should always be a sufficient reserve supply on hand so that one is not forced to go into the market to buy to cover emergency needs.

In the care of linen, so far as possible stained linen should be used for cases that are likely to stain it, instead of spotless linen. Every hospital executive knows that even with the best of care and with the use of all kinds of stain-removers linen is apt to become stained. Every executive also knows that no one when confronted with a bureau scarf that has been used as a dust cloth confesses any knowledge of it. One simple precaution in the care of linen is to possess a supply of laundry bags of heavy material; otherwise a perfectly new spread or sheet, used as a laundry bag, will become badly ruptured by a fall of several stories down a linen chute, and badly soiled and stained by being dragged over a floor. Another precaution is to "kill the rat." Rats find their way even into absolutely new hospitals, and they seem especially fond of blood-stained linen.

The one place above all where care must be used is in the laundry, for most linen is "washed out" rather than "worn out." The first, best and greatest precaution is the use of soft water; especially fortunate is that laundry that has a supply of naturally soft water. In such a laundry by the use of a mildly alkaline soap, with careful rinsing and with the use of very little bleach or sour, linen can be washed day after day until it is in rags and still it will retain its original bright color and its sweet odor. With the advent of water-softeners, even if the water supply is hard, the same results can be obtained. The saving in supplies will soon save the original cost of the softener.

Issuance of Linen

Issuance of all hospital linen should follow the invariable rule of good hospital management for issuing supplies which is only by signed requisition from the store. Goods are requisitioned for two purposes: (1) replacement of worn-out articles turned in for exchange when beyond repair, and (2) new goods. New goods are issued when goods have disappeared and when the inventory reveals that there are less articles in circulation than a carefully determined standard shows to be

necessary. These fresh goods should be marked before they go into circulation.

A Scheme of Marking Linen

In marking linen, a hand marking machine with dies is satisfactory for many kinds of linen, though for marking small lots a type-setting machine is better. Personal linen should have name tapes sewed on, always in the same place on the same class of garments, though sometimes a pen and indelible ink will be necessary in the laundry to avoid sending articles back for marking. All linen should be dated as this gives information which may be of great value. Dating shows how well goods wear and is a guide when purchasing the same type of articles. If too many goods wear out sooner than they should, the laundry is at fault through too hard washing or the use of too much bleach or sour. Enough marks should be used to prevent unnecessary handling of goods when folded; on the other hand too much marking makes goods appear "institutionalized." There are cases where this practice is justifiable, however, to avoid the theft of articles. In general it is better to mark linen with the name of the hospital, the date, the department to which it belongs, but not the particular part of that department. The writer recommends marking sheets with the word WARD, but not with the particular ward. This allows greater flexibility in distribution, as at a given time Ward A may be quite full and Ward B nearly empty, and in a few days the condition may be reversed, so that if each had its own linen individually marked one ward would be short one day and the other ward have too much. If the linen is marked only WARD, it can be sent at once to the place where it is most needed.

Handling Soiled Linen in the Laundry

In laundering hospital linen the following points have been found valuable. Soiled linen should be sorted so as to save time for the washing machines and wear on the goods, since comparatively clean linen does not have to be subjected to the longer washing which heavily soiled linen requires. Soiled or stained linen from the operating room, delivery rooms or wards should be placed in special bags for that purpose and washed separately before being put into the washers with other laundry. Such care will eliminate much of the stained linen that may otherwise be found in general circulation in many hospitals.

An added problem in the handling of laundry in the wards is the care of linen used by patients with infectious diseases—linen which must be sterilized before it can again be used. This should be collected by the nurse at the bedside of the patient in small laundry bags made of different material than the regular bags. These bags may be collected with the regular large-sized bags containing the ordinary soiled linen. When reaching the laundry the small bags are immediately taken from the others, and the contents emptied into a washer kept particularly for this purpose, and which is so connected with live steam that the clothes may be completely sterilized in the washer before going through the regular process of washing. If this is not feasible, it may be thoroughly boiled on the ward and sent to the laundry in the regular laundry bags though this method is not so good as the previous one.

Hand ironing should be avoided whenever possible. Turkish towels and wash cloths can be satisfactorily handled by passing through a tumbler dryer and then folding. They are softer, fluffier and more absorbent than when passed through a flat-work ironer, and the flat-work ironer can usually be kept running to capacity with flat-work, gowns and aprons. Much work that was formerly done by hand can now be done on body ironers and ironer-presses, and with a little touching up by hand cannot be distinguished from all handwork, saving greatly in time.

"Laundry Square" for Personal Linen

For personal linen a room fitted with compartments for each individual is almost indispensable for accurate and rapid handling and sorting, and a laundry square for each person should be insisted on. By "laundry square" is meant a piece of heavy washable material 1¼ yards square used instead of the usual laundry bag to carry personal linen to and from the laundry. The use of this facilitates the counting and sorting of the individual linen. It also makes it possible to convey without injury certain starched articles which would be badly crushed if put into a laundry bag. Uniforms can best be placed on wooden hangers after ironing and taken in large quantities on a pole to the nurses' residence.

In a well arranged laundry the goods are received in the sorting room and from there travel a direct path through washer, extractor and finishing machine. The path should end at a set of storage shelves where the goods are starched. From these shelves the orders for the various parts of the hospital are filled directly into the delivery baskets made of wood and mounted on rubber or composition wheels. Requisitions are made out on special forms and are for only one day's supply, or for two days' when Sunday or a holiday follows.

The elimination of a linen room saves several handlings of the linen: (1) from the laundry to the truck, (2) from the truck to the shelves in the linen room, and (3) from the shelves back into the delivery basket, as these three movements are replaced by the one handling from the storage shelves in the laundry to the delivery baskets. By this system "one day service" can be maintained provided the laundry takes its half holiday on Wednesday instead of Saturday afternoon. It also makes it possible to keep in circulation only a little more than twice the daily standard of linen, instead of three times the daily standard which would be required if two-day service were maintained. Unless inspection is made from time to time, a head nurse who is either careless or over-careful, will accumulate linen on her shelves not in active circulation and some other part of the hospital will lack its required supply. It seems to be an axiom in hospital work that the greater the amount of material in circulation the greater the use and the larger the amount of loss.

All articles needing mending are withdrawn by the laundry employes, placed in a special basket and sent to the sewing room for repair. The best place for this withdrawal of flat-work is just after it has passed through the ironer and before it is folded. Power sewing machines are used to repair all that is worth while, and anything that cannot be repaired is held for discarding and replacement by the housekeeper. The material discarded can be used for patching, for cleaning rags, or if too small can be sent with other clean material to a factory to be picked up for waste cotton.

A definite standard must be set for each place supplied if the stock of linen is to be kept at a satisfactory point, that is, with neither too much nor too little in circulation. Thus each ward has a standard depending upon the number of patients and the variety of patients, as medical, surgical or obstetrical. A floor of private rooms would of course have an entirely different standard than a ward. To keep the standard filled a simple form of bookkeeping is required. Each month on a definite day an inventory is taken of all the linen in the wards and private floors on the shelves and in use on the beds, in the operating rooms and in the laundry. These can be taken on the same form of laundry list that is used for requisition. They are then turned in and totaled. The totals can then be tabulated on a ruled form and in an adjacent column the amount which has been replaced set down, so that one may know how rapidly goods are wearing out. The amount shown on the inventory is then subtracted from the standard, and this gives the amount of new linen which must be requisitioned from the storeroom. While it is difficult to get the inventory made as carefully as it should be done, still perseverance will greatly improve this work, which is a great aid to hospital economy and efficiency.

PARLIAMENT HEARS COMMITTEE'S REPORT ON MENTAL HOSPITALS

Attacks upon the administration of public mental hospitals in England, made in a recently published volume, "The Experiences of an Asylum Doctor" by Dr. Montagu Lomax, gave rise to the appointment of a committee to investigate conditions. The committee has made its full report to Parliament.

As a result of the investigation the committee found that the book draws attention to some aspects of asylum administration which have long been recognized as admitting of improvement, that many statements in the book are based on hearsay evidence or on none at all, and that many deductions are unjustified by facts. It further reported that the volume contains many "gross exaggerations" and that although Dr. Lomax attacks what he calls a "system" the committee was unable to find that any "system" producing uniformity of treatment exists. No allowance was made by the author for the quite abnormal conditions created by the war, it was said.

However, arising out of the investigation some important recommendations were made by the committee; among them were the following:

That for the future the size of mental hospitals should so far as possible be limited to accommodations for 1,000 patients.

That in classification of patients account should be taken of their home conditions.

That the superintendent of a mental hospital should be a medical man, having undivided control of the institution, and that a small advisory board, preferably associated with the board of control should be available for consultation by visiting committees when making these appointments.

That the number of assistant medical directors should be increased and that facilities for study leave be given them.

That the departmental committee on the nursing service should consider whether some distinction could be made between the two duties of mental nurses—namely, nursing proper and social duties—and that the present rigid system involving short shifts of duty should be discontinued.

Other recommendations relate to greater variety of diet, to the appointment of a special occupation officer at each institution, to the better organization of aftercare work and to the possibilities of coordination of research in a few fully-equipped institutions.

WOULD NAME COUNTY SANATORIUM FOR ITS PROMOTER

The new tuberculosis hospital in Calhoun County, Michigan, will be known as the Kimball Hospital, if a movement which is now under way is successful. Friends of the late Dr. Arthur S. Kimball of Battle Creek wish thus to honor the memory of the man who was for many years director of the Calhoun County tuberculosis clinic and who worked ceaselessly for the establishment of the county sanatorium which was recently authorized by the taxpayers.

SHOULD THE HOSPITAL PHARMACIST HAVE A PLACE ON THE PROFESSIONAL STAFF?

By EDWARD SWALLOW, Pharmacist to Out-Patient Department, Bellevue Hospital, New York.

THE great progress made in medicine during the past few years has naturally reacted upon the profession of pharmacy which now plays an important part in the practice of medicine. This applies particularly to hospital pharmacy, where the pharmacist is brought into the closest relations with the physicians and surgeons.

In the hospital the pharmacist is purely a professional man as he is called upon to practice only his art and science in carrying out the requirements of the medical men. His profession demands knowledge of no mean order, skill and integrity, and he is engaged in a calling in which there is a well defined legal and moral duty and an obligation toward public health and life. He deserves all the honor and dignity possible in his important calling; yet we find that in very few hospitals is the pharmacist on the professional staff. His proper place would seem to be on the house staff among the other professional men such as the resident physicians. In the great majority of hopitals the pharmacist though a professional man is upon the administrative staff where he does not rightfully belong.

Accuracy and Watchfulness Essential

Grave responsibilities rest upon the shoulders of the hospital pharmacist who not only has to exercise constant vigilance in compounding and preparing the medications but also has to see to it that nothing goes into the wards which has lost its virtue by any form of deterioration.

Accuracy and watchfulness are absolutely essential in the hospital pharmacy all the time as the life and health of the patient are at stake and any deviation from the doctor's orders is likely to effect the treatment seriously.

The hospital pharmacist is there to give the medical men his professional services; he should work with all his ability and art according to the highest ethics and honor so as to reflect credit and dignity on his profession, and enable patients to reap every advantage from the physician's knowledge and experience. Slipshod, inaccurate methods of performing his duties react unfavorably on the good repute and professional ability of the physician, and endanger the health and safety of the patient who is apt to judge the value of the medical service by the quality of the medicine prescribed.

The rapid increase in the number of hospitals and their fuller development will bring the hospital pharmacist into still closer relations with the physicians and nurses, making his profession of increasing importance to hospitals and the public.

Pharmacist Instructs Nurses

In a few hospitals the pharmacist is called upon to give instruction to the nurses, and in the near future this will form part of his duties as he is peculiarly qualified in every way to impart much useful knowledge, both theoretical and practical, to the hospital nurses who thoroughly appreciate its importance in their calling.

In fact hospital pharmacy is rapidly enlarging its scope and its possibilities, and, recognizing this, some hospital pharmacists who are members of the American Pharmaceutical Association have formed a special group within the association devoted to the interests of hospital pharmacy, the solving of problems, the exchange of formulas, etc., with the idea of improving and increasing the importance of the pharmacy department in American hospitals. This means better service to the hospitals by the pharmacists and shows worthy desire to meet all the requirements of the medical profession in the spirit of helpfulness.

The American Pharmaceutical Association, recognizing the purely professional activities of the hospital pharmacist, is giving to each one who has not become a member an invitation to join in the aspirations and attainments which the association strives after for the uplift of pharmacy, the comity of relations between physicians and pharmacists and the benefit of mankind.

SOME SUPERLATIVES

The greatest sin is FEAR.
The best day—TODAY.
The greatest mistake—GIVING UP.
The most expensive indulgence—HATE.
The greatest trouble maker—TALKING TOO MUCH.
The best teacher—ONE WHO MAKES YOU WANT TO LEARN.
The best part of religion—GENTLENESS AND CHEERFULNESS.
The meanest feeling—JEALOUSY.
The greatest need—COMMON SENSE.
The cheapest, stupidest and easiest thing to do—FINDING FAULT.
The best gift—FORGIVENESS.

—Dr. Frank Crane.

THE NEW EVANGELICAL DEACONESS' AND NURSES' HOME IN CHICAGO

By BISHOP SAMUEL P. SPRENG, D.D. Chairman, Board of Directors, Naperville, Ill.

THE Deaconess Society of the Evangelical Association, a religious denomination, was organized by authority of the general conference in 1903. Its primary purpose is the training and employment of deaconesses for Christian service, and believing that a deaconess should be a trained nurse for the proper care of the sick, as well as a social and religious worker, a hospital was soon erected in Chicago as a part of this training school. Nurses were later on also admitted for training, and the training school of the Deaconess Society became also a training school for nurses, accredited under the state board of Illinois.

From the beginning the housing and care of nurses in training as well as the deaconesses became a serious problem. The Society lacked the facilities for giving the students proper home conditions. Many of the girls came from the better class of homes and were accustomed to modern conveniences and comforts, to say nothing of pleasant and attractive surroundings. Away from these, many of them became homesick. The experience in the unwonted atmosphere of the hospital made them long the more for something like home life and comfort when off duty. It was this, and the conviction that a wholesome morale is essential to the best results in study and service, that led the Society to plan for the erection of a suitable home for these girls, and one which would also ultimately provide a comfortable place for aged deaconesses and for those who by illness have become incapacitated for service.

The Evangelical Deaconess and Nurses' Home

Ground was accordingly purchased one half block west of the hospital on Wisconsin street and a block from the street car line. The location is quite near the beautiful Lincoln Park. Here the new home was erected in 1920-21 on the corner of Wisconsin and Hudson streets. The new hospital building, which is being planned, will be erected just across the street. The plans were drawn by the architect, H. E. Pridmore, who also superintended the erection of the building.

The residence is a stately modern building, practically four stories high, and occupies a ground space of 105x44 feet. From the standpoint of design and construction it represents perhaps one of the most up-to-date nurses' homes in the country. The facade is an adaptation of Colonial architecture carried out in tapestry brick and laid in Flemish bond, with a liberal use of cream colored terra cotta trimming, including the arch over the main entrance and heavy cornice the whole length of the building. The structure is fireproof throughout.

Floors and interior supported columns are constructed of reinforced concrete, the open joist system being employed. The floors throughout are finished smoothly in cement, no wood being used. On top they are coated with a patented binding solution to prevent the accumulation of dust, thus making the floors sanitary and easily kept clean. The entire walls and ceilings are finished in a hard plaster, applied on expanded metal lath.

One unusual feature of the building is the generous modern facilities, which the building committee insisted on providing for the nurses. There is a toilet, lavatory and bath between each pair of bedrooms, the bath being in a separate compartment, thus giving the maximum utility and at the same time privacy. In fact the conveniences are equal to those in a first class modern hotel.

The arrangement of the first floor provides a reception room off the entrance hall. At the southeast corner the principal has a private suite of three rooms, a living room, bedroom and bath. Next to this suite is a private room provided with all conveniences for the assistant principal. There are also good accommodations for the matron. Another attractive feature on this floor is a small kitchen and dining room adjoining, for the use of

Looking down the attractive living room.

A student nurse's room.

deaconesses and nurses. This is so arranged that when off duty they may prepare refreshments for themselves. A splendid living room at the west extends across the entire width of the building; it is tastefully decorated, has panelled ceilings and walls and a fine large mantle and fireplace at the north end. The room is elegantly and massively furnished and well lighted. Opening into it is a spacious library with bookcases, reading lamps and tables.

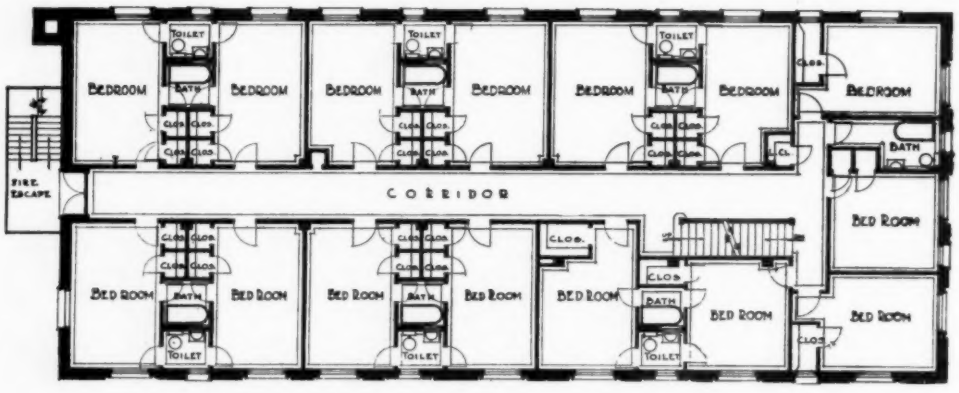
Provides Gymnasium Facilities

The building has a high and commodious basement. Here again the comfort of the girls has been given first consideration. Stretching across the east end is a gymnasium, the floor of which is several feet lower than the rest of the basement in order to give the proper height. This room is provided with an abundance of light and air. Adjoining are shower baths and toilets. The central portion of the basement area contains ample trunk rooms and storage facilities. There are also special quarters for the use of the janitor and fireman. The boiler room, coal room, etc., occupies the west end of the basement. Heating is furnished by means of a hot water system.

New Hospital Being Planned

The entire building, both as to its interior and exterior, is characterized by simplicity, symmetry, beauty and utility. It leaves little to be desired. The management is convinced that the home has already contributed much to the contentment, the efficiency and the happiness of deaconesses, nurses and students in training.

The Society is now planning the erection of its long contemplated and greatly needed new hospital. This also will be erected on Wisconsin street. In architectural design it will harmonize with that of the home, will have a capacity of 100 beds, and will be modern and up-to-date in every particular.



Typical floor plan of Evangelical Deaconess and Nurses' Home.

HEADS FARGO HOSPITAL

Mrs. G. W. Fuller, R.N., has been appointed superintendent of St. Luke's Hospital at Fargo, N. D., to succeed A. O. Fonkalsrud, who resigned in June. Mrs. Fuller is a graduate of St. Luke's Hospital, St. Paul, Mr. Fonkalsrud is at Minot, N. D.

An Announcement

The Modern Hospital Publishing Co., Inc., announces a competition for plans of a

Small Community Hospital

in order to stimulate a greater interest in the construction of economically arranged and architecturally artistic hospitals, and in order to provide boards of trustees of small institutions with a group of suggestive plans that will make for more efficient care and treatment of the sick.

$1,000 in Prizes

will be given to architects through the competition, the general program of which was announced at the twenty-fourth annual conference of the American Hospital Association at Atlantic City, September 25-28. Three cash prizes of $500, $300 and $200 will be awarded, and two honorable mentions made.

The detailed program for the competition is given on pages 313-315 of this issue.

The MODERN HOSPITAL

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ANOTHER YEAR

THE twenty-fourth annual conference of the American Hospital Association has come and gone. Our comments, commendatory and critical, will be found on another page. Our interest now lies in the future and as we turn our thought in this direction we find cause for encouragement in Mr. Bacon's address of acceptance of the office of president. It is evident he intends to make the coming year one of accomplishment for the American Hospital Association. He says specifically, "Where there is no growth and development, there is deterioration." Mr. Bacon has the interests of the American Hospital Association too much at heart to tolerate disintegration; consequently we may, with good reason, look for growth, perhaps rapid growth. There will undoubtedly be marked growth in the membership of the association, both personal and institutional. There will be growth in the number of service bureaus, if an additional number is needed to serve the field effectively. Especially will there be growth in the number and activities of state and provincial associations, and where individual state associations are not feasible, geographical sections, in order that all of the United States and Canada may be fully organized to work as individual units or together, as needs may dictate, for proper laws and standards for the prevention of disease and the care of the sick.

Mr. Bacon's standing committees for the coming year were announced before the convention adjourned, and we understand that much of the program of next year's conference is already mapped out and ready to be acted upon as soon as the association and board of trustees decide upon the time and place. We believe Mr. Bacon will translate the spirit of his presidential address into action, and that we may look forward to one of the association's most fruitful years.

A SUBSTITUTE FOR THE MISSING INTERN

THE normal activities of the intern have an important bearing on the quality of hospital service. Hospitals which are deprived of the services of interns labor under a handicap, and may easily be frustrated in any attempt at the proper organization and standardization of their clinical work. An inquiry made by THE MODERN HOSPITAL in 1919 showed how many of the smaller hospitals of the country were without interns, and how keenly the need of them was felt. It was hoped that the inquiry would be followed speedily by the training of a group of non-medical women to serve as substitutes for interns where no interns were available, but that hope has not yet been realized.

It is futile to talk about perfecting the clinical records of small hospitals, unless some one can be brought into the service of such hospitals who is capable in some degree of taking the place of the missing intern. The shortage of interns was greatly accentuated during the war, but the underlying conditions are such that the cessation of the war did not bring adequate relief; the number of hospital beds and the demand for services incidental to the diagnosis and treatment of hospital patients, have increased and are still increasing at a rate far beyond the rate of increase in the number of graduating medical students. The American Medical Association has shown that the medical schools of today are prepared to graduate only about one-half the number of men that could be used to advantage as interns in the six or seven hundred hospitals that are approved by the association as possessing the necessary equipment and qualifications for the training of interns; and here no account is taken of the immensely greater number of institutions that do not possess such qualifications.

With the best will in the world, the visiting staffs of hospitals that have no interns cannot see

patients promptly enough after the arrival of the patients in the hospital; they cannot take proper histories, record operations satisfactorily, secure adequate and timely assistance at operations, render prompt first aid in minor accident cases, make adequate clinical notes, make urinary analyses and blood examinations with reasonable frequency, or give suitable attention to infected wounds which require time-consuming treatment. For all this work resident assistants are needed.

The solution of the problems which was suggested in these columns three years ago is the inauguration of a course of training for non-medical clinical aids. Women have been intensively trained and are being successfully used as anesthetists and as laboratory technicians, but such women have been trained to serve exclusively in the capacities named and are not qualified for the broader work of clinical aids; moreover, most of the women who have taken this special training have been rapidly absorbed by the larger hospitals as a supplement to the intern staff, and have brought no relief to the smaller institutions that have no staff of interns to be relieved or helped out in this way.

In from twelve to eighteen months an intelligent graduate nurse can be taught to perform all that part of an intern's work which does not involve diagnosis and treatment, except perhaps some of the more difficult laboratory and bedside procedures. An appropriate course of training would include Anesthesia, First Aid, Surgical Dressings, Laboratory Technique, History Taking, Technique of the Operating Room, and Clinical Records, to which might be added optional courses in stenography and typewriting. A carefully chosen committee could easily map out the details of such a course, which could then be given as post-graduate instruction in schools of nursing associated with hospitals possessing sufficiently varied and extensive clinical and laboratory resources. It is hoped that this suggestion will soon assume practical shape, and that it will receive the vigorous support of the medical profession, for a competent substitute for the missing intern would be a godsend to the smaller hospitals.—S. S. GOLDWATER, M. D.

TRUE COOPERATION IN HOSPITAL ADMINISTRATION

OF ALL the hard-worked words in our language, with the exception of poor old, threadbare "efficiency," none is more abused than "cooperation." It is the shibboloth for every movement from birth control to Old Home Week. "Cooperation is promised." "Cooperation wins the day." "He will (won't, must) cooperate." Every change is rung on this once virile, useful word until it has almost been reduced to the level of the argot, a jargonesque shadow of its former self.

Yet it is a good word when used in its correct sense, "to work with." Too frequently, it is employed to express the thought "to work for." On the contrary, it means "to work together," "to work hand-in-hand and side-by-side," "to labor collectively for a common end."

First of all cooperation means that all parties common to the job shall be on it; not that one fellow shall do a little bossing and then excuse himself to shoot a round of golf, while the others continue to pile into the work. Furthermore, it conveys the thought that they shall work together, each one on his own part of the task, and, if that particular gang is ever again to be induced to attack a similar task with the same sprightly verve, that there shall be an equitable division of the results of their cooperative toil.

There is another factor. Everybody on the job must know what end is aimed at if his work is to be done in intelligent coordination with others and equally should have an opportunity of self-expression if the product is to be really workmanlike and artistic in the true sense.

Everybody on the work in hand must be genuinely interested, hence the boss must keep the workman's viewpoint carefully in mind; in other words he must keep his eye on the morale. Cooperation is teamwork, the old "one for all and all for one" words set to modern music.

Of all the collective efforts of man, there is probably none where true cooperation counts for more than in hospital administration. The superintendent who drives his people along cannot achieve the results of the man who leads them, because to lead them he must get down off his pedestal and walk with them. He must cooperate with them if he wishes them to cooperate with him. The manager who says, "I can't get him to cooperate," is nine times out of ten unwittingly confessing that he himself won't cooperate, which is the same thing as saying that he lacks loyalty and hence cannot inspire it in others.

This idea goes all through the little community which is the hospital. A green probationer will have the meanest old grouch in the chronic ward fairly hunting for jobs to do, while the head nurse will be obeyed but grudgingly. One training school will run as smoothly as a well-oiled machine; another will be in a turmoil of discontent. Remove the cooperant from the one and the disoperant from the other and all will be changed. One surgeon will receive only the scant measure of just

service, while another, not his professional equal by half perhaps, will find interns, nurses and orderlies striving for the opportunity to work with him. The one has the quality of coherency, of drawing people about him. He is a cooperant. The other is a repellant, disbursive force. He is a disoperant.

The great enemy of real cooperation is an exalted ego. Like Bimi, it is a case of "too much ego in his cosmos." This begets forgetfulness of the fact that loyalty is perpendicular and must therefore run down as well as up. It induces a myopia to the human element in toil. Men can be brought to love almost any job because they transfer to it their affection for the boss with whom they are cooperating. Equally, and far more easily, they can acquire a bitter hatred of the job because they detest the man over them.

The Frenchman who counseled that one should put himself in the other fellow's skin had a pretty accurate notion of true cooperation.

THE EXTRA PAIR OF TROUSERS

WHEN we learn of concerns contributing to hospitals with whom they seek to do business, we are reminded of the old style of clothing merchant who found it necessary to throw in an extra pair of trousers in order to sell a suit of clothes. This particular species of merchant is not altogether extinct even now, but he is usually not numbered among the progressive and reliable merchants of the town who conduct their business on sound business principles. Of course, the merchant who offers the extra pair of trousers is in business to make a profit, and in one way or another the purchaser pays for the trousers; it could not well be otherwise. Are the hospitals so foolish as to think that in accepting contributions from merchants at large, they are really getting a pair of trousers for nothing. We are loathe to think so, for when contributions are made a matter of compulsion instead of generosity they defeat the very purpose for which they were intended. The continuance of this practice simply postpones the day of sound business administration among hospitals and encourages unscrupulous practices at the expense of honest manufacturers and merchants.

THE LIMITS OF HUMAN VERSATILITY

NO OTHER field exists in which so great a variety of merchandise must be selected and purchased by a single individual as in the hospital. The range of products runs the entire commodity gamut: structural materials and laundry supplies; foodstuffs in greater variety than needed in the modern hotel and with more exacting problems of food service; every conceivable type of general furnishings, overtopped by clinical and scientific requirements of varied nature; needles for the sewing room; coal for the furnace; soaps and cleansers; in some instances, even garden and farm equipment.

The range of exact knowledge necessary on the part of the hospital executive responsible for the purchase of these widely varied products wellnigh exceeds the limits of human versatility.

In the larger institutions comprehensive buying records often supply a proper background; in the smaller hospitals the problem is too often solved by orders being placed without proper knowledge, resulting in needless waste and obvious inefficiency.

Because of a clear recognition of these purchasing problems of the hospital, THE MODERN HOSPITAL YEAR BOOK was conceived and developed. Through this volume, information is at once available as to suitable sources of supply for practically every item used in the construction, equipment and operation of a hospital. The far-sighted, progressive superintendent will at once recognize the practical value of this extensive information; its use will be a constant aid to more efficient and economical purchasing.

The third edition of the YEAR BOOK, which is now being distributed, is a veritable encyclopedia of purchasing information in compact and usable form.

STRASBOURG MEDICAL FACULTY VISITS U. S. HOSPITALS

A delegation of members of the faculty of the medical school of the University of Strasbourg, Alsace, is in the United States as the guests of the Rockefeller Foundation for the purpose of studying the organization and methods of American medical schools.

The University of Strasbourg as organized under the French, although still in its formative stage, is one of the most important medical schools in France. In making this trip, which includes England as well as the United States, the Strasbourg faculty will have an opportunity for an exchange of ideas and a comparison of methods in medical education.

The visiting commission is made up of the dean, Dr. Georges Weiss, professor of biophysics, and six other influential members of the faculty, representing both laboratory and clinical branches—Dr. Léon Blum, professor of clinical medicine; Dr. Paul Bouin, professor of histology; Dr. Camille Duverger, professor of ophthalmology; Dr. P. Masson, professor of pathological anatomy; Dr. Maurice Nicloux, professor of physiological chemistry; and Dr. Lucien Pautrier, professor of dermatology and head of cutaneous diseases clinic.

After a brief stay in New York members of the commission, following their special interests, will visit a few of the leading institutons for medical teaching and research in the United States.

TWENTY-FOURTH CONFERENCE EMPHASIZES THE EDUCATIONAL FEATURES OF EXPOSITION

IT IS safe to say that delegates and exhibitors alike left the twenty-fourth annual convention of the American Hospital Association feeling that the exhibit of equipment and supplies was by far the best the association has ever had. Space was ample and well suited to its purpose. The exhibits were attractively arranged and the program provided ample time for their inspection, quite in contrast to last year's arrangement.

The effort to tie the exposition up more closely with the association through various exposition committees and their reports, while partially successful, fell far short of being the success anticipated by those who sponsored the idea. This, however, was far from being the fault of the exposition committees or their chairmen. The reports of these committees were admirable and gave evidence of careful preparation. They contained little, however, that related to the actual exhibits at the convention; they were rather in the nature of formal papers on the subjects the committees were asked to survey. To give the delegates full advantage of these reports, they were scheduled to be read at the second and third general sessions of the conference, but unfortunately some of them were not submitted until Wednesday and one was left until the closing day of the convention, despite the fact that the chairmen of all of the committees were present and had their reports ready for submission Tuesday morning. It is regrettable that the plan was not carried out as originally conceived.

Practical Problems Received Chief Emphasis

There were some who felt that too much of the time of the convention was devoted to the exposition and to the various reports on the physical equipment and management of the hospital and too little to some of the broader questions now agitating the hospital field. There is doubtless some ground for this criticism. The pendulum, having swung too far in one direction at the Montreal meeting, swung perhaps a little too far in the opposite at this conference. Another year may see the convention strike a happy medium. Perhaps one way to gain this desirable end would be to have the more formal parts of the reports of the exposition committees distributed in leaflet form, leaving time free for the committees' informal presentation of the noteworthy features of the exposition, as well as for a few more papers on other aspects of the field.

Like the West Baden convention, the Atlantic City conference was characterized by two or three definite accomplishments. Hospital administrators, trustee's and architects will be especially grateful for the admirable report on flooring submitted by Mr. Frank E. Chapman, its chairman. The report was supplemented by a very illuminating exhibit, showing the manner in which various flooring materials stood up under the actual tests made by the committee. A very helpful report, supplemented by an exhibit, was also submitted by the committee for the renovation of gauze, of which Dr. A. B. Denison was chairman.

THE NEW SLATE

President

Asa S. Bacon, Presbyterian Hospital, Chicago.

President-Elect

Malcolm T. MacEachern, M.D., Vancouver General Hospital, Vancouver, B. C.

First Vice President

A. K. Haywood, M.D., Montreal General Hospital, Montreal, Quebec.

Second Vice President

Miss Charlotte A. Aikens, Detroit, Mich.

Third Vice President

R. G. Broderick, M.D., Alameda County General Hospital, San Leandro, Cal.

Treasurer

Robert J. Wilson, M.D., Health Department Hospitals, New York.

Trustees

The Rev. Maurice F. Griffin, St. Elizabeth's Hospital, Youngstown, Ohio.

A. C. Bachmeyer, M.D., Cincinnati General Hospital, Cincinnati, Ohio.

To Have Committee on Accounting

The convention took positive action on but one subject—the appointment of a committee on hospital auditing and accounting. Feeling that the proper functioning of such a committee would entail too great expense, the resolutions committee

suggested the appointment of a committee to take this matter under consideration during the year and undertake such activities as would not for the present involve the association in additional expense. The section on trustees also placed itself on record as opposing the diversion of portions of legacies to hospitals, homes and other charitable or religious organizations for state purposes through the means of a collateral inheritance tax or in any other manner.

Acting on the suggestion of a small group of hospital trustees which met at the West Baden conference the board of trustees of the American Hospital Association established a section on trustees. This section held its first meeting at Atlantic City. Some seventy-five trustees and superintendents were in attendance and a number of important questions were discussed informally. The full significance of this first meeting of the section on trustees is not realized; time alone will reveal it. As an association of institutions rather than of superintendents the American Hospital Association must increasingly command the interest and support of hospital trustees. Last year's informal meeting marked the beginning of this metamorphis.

Mr. Bacon, the incoming president, with Mrs. Bacon and a friend approach the Million Dollar Pier.

One of the most helpful features of the West Baden convention was the active reception committee of the Indiana Hospital Association, which among other things made it its business to see that delegates wishing to meet each other received the necessary introductions. This feature of the Atlantic City convention was conspicuous by its absence and was made the subject of criticism at the closing session. The need for a reception committee, one of whose functions would be to introduce delegates to each other, was greater at Atlantic City than at West Baden. Since to many the chief value of these conferences lies in social contact and informal discussion it is hoped incoming officers will give this subject the consideration it deserves, and work out some practical plan under which delegates who desire to meet each other may do so easily.

The round table discussion was handled well by Mr. Asa S. Bacon. Delegates were definitely designated to lead the discussions and in the absence of further comment the chairman passed promptly to the next question. Under this plan a goodly number of questions were discussed during the time assigned to the round table and there was little lapse of interest.

Those who were responsible for the non-commercial exhibits are to be congratulated upon the attractive showing they made. These exhibits were a splendid addition to the exposition; that of the American Association of Occupational Therapy was especially noteworthy, being the largest and most diversified exhibit of its kind ever shown at an annual convention.

Association Is Truly International

Since the membership of the association is made up of citizens and institutions of both the United States and Canada, the association is international in character; it is especially fitting therefore that both countries were represented in the decorations in the main assembly hall by their flags. The association did well, moreover, to give further emphasis to the international character and scope of its work by naming Dr. Malcolm T. MacEachern as its president-elect. Dr. MacEachern is a forward-looking executive, a tireless worker and one who has the interests of the association very much at heart. With Mr. Bacon and Dr. MacEachern as its chief officers, the association has every reason to look forward to two years of constructive work.

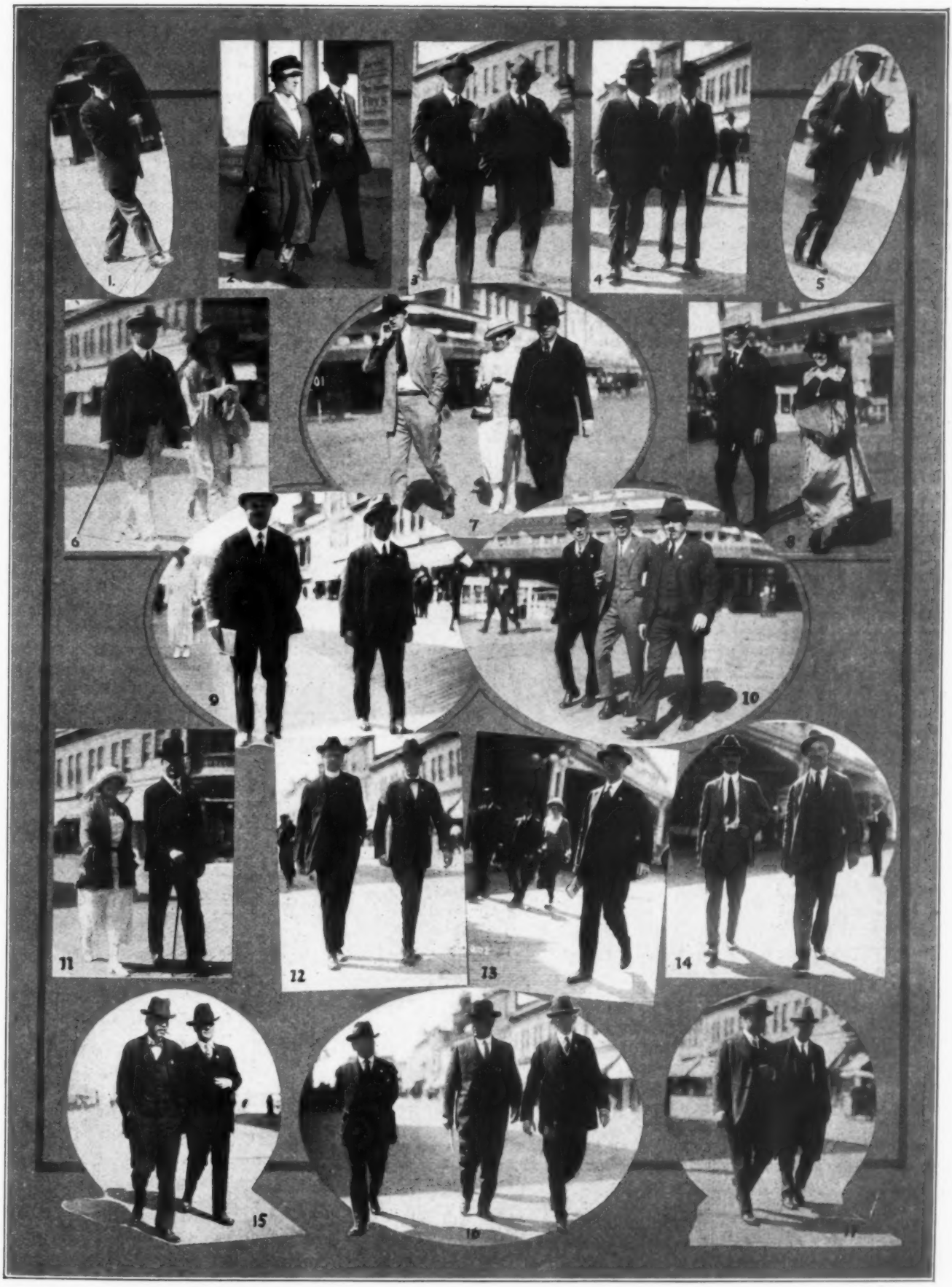
HOLD MODEL CARDIAC CLINIC

Fifty persons witnessed the model cardiac clinics held daily in the booth of the New York Association for the Prevention and Relief of Heart Disease. The clinics were put on in cooperation with the Committee on Out-Patient Work. The clinics showed the procedure from the time the child was admitted to the institution until his discharge.

Of interest to those interested in the treatment of heart disease was the demonstration of a polygraph or pulse wave recorder with a typical heart case.

A representative of the Philadelphia Association for the Prevention and Relief of Heart Disease was present in the booth and answered inquiries about the several cardiac clinics in operation in Philadelphia hospitals.

SOME FAMILIAR FIGURES WITHOUT AS WELL AS WITHIN CONVENTION HALL



(1), J. M. Evans; (2) Dr. Joseph H. Morrow; (3), Dr. Easton (right); (4), Dr. C. S. Woods and Frank E. Brooke; (5), Dr. D. H. Fuller; (6), Walter H. Conley and Mrs. Conley; (7), Dr. J. D. Spelman and Frank E. Chapman; (8) Dr. McGuire; (9) Reuben O'Brien and Dr. Glennon; (10), Luther H. Lewis, Dr. W. P. Morrill, and an exhibitor; (11), Dr. Nevin; (12), Father O'Connell and Howell Wright; (13), Dr. L. H. Burlingham; (14), Dr. S. B. Ragsdale and Dr. Harold W. Hersey; (15), Richard P. Borden (left); (16), Henry C. Wright (center); (17), Dr. C. W. Munger and E. S. Gilmore.

THE STORY OF THE CONVENTION

THE opening general session of the twenty-fourth annual conference of the American Hospital Association was called to order by President George D. O'Hanlon, superintendent of Bellevue and Allied Hospitals of New York, at 2:30 Monday afternoon in the theater on Young's Million Dollar Pier. Following an invocation by the Rev. J. H. Robinson of Christ's Hospital, Cincinnati, Dr. J. J. Mooney of Jersey City, speaking on behalf of Governor Edwards of New Jersey, welcomed the delegates to Atlantic City and the state of New Jersey and expressed the hope that their stay would be enjoyable and that the meeting would have far reaching results.

Taking as his title "The Great Question," Doctor O'Hanlon in his presidential address, which will be found on page 269 of this issue, traced the growing activities of the American Hospital Association since its inception, reviewed some of the activities of the association's board of trustees during the past year and made a plea for hospitals as centers for social service, the development of after-care work and the extension of out-patient service.

The report of the trustees, (page 316) was read by Mr. Richard P. Borden of Union Hospital, Fall River, Mass. This report was followed by that of the treasurer, which showed that the association has a balance as of September 1 of $3,622.34. The report of the executive secretary followed and will be found on page 317 of this issue. The report of the membership committee showed that as of September 1 the association had a total institutional membership of 473 and a total personal membership of 1,543. The committee called special attention to the constitutional provision creating associate institutional membership and expressed its belief that it is to the best interests of every hospital and every hospital executive that all organizations connected with hospitals affiliate themselves with the American Hospital Association as associate institutional members, thus receiving the literature sent out by the association and obtaining the trend of thought and action as expressed in and through the association. This report will be found on page 318.

President-elect M. T. MacEachern on the Boardwalk. He looks happy.

Following the report of the membership committee, Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, submitted the second report of the committee on hospital forms and records with particular reference to annual reports. In this report, (page 325) the committee submitted an outline of a standardized report and recommended that, in the absence of a uniform medical nomenclature, the publication at this time of medical statistics in hospital reports should be omitted and that a committee of representatives of interested national organizations be formed for the purpose of establishing a standardized medical nomenclature. The committee has been continued for another year and will submit a final report at the next convention.

In the absence of the chairman of the legislative committee, Dr. C. G. Parnall, medical director of the University Hospital, Ann Arbor, Mich., the report of this committee was not submitted.

In submitting his report as chairman of the committee on relations between hospitals and states and cities, Mr. John E. Ransom, superintendent of Michael Reese Dispensary, Chicago, stated that the committee was not prepared to submit its final report to the association, but would make a detailed report some time during the coming year. Data thus far collected, however, indicated that states and cities, with few exceptions, are not concerning themselves with the regulating of hospitals. Yet regulation is in effect in some of our states and cities, and laws affecting hospitals may be passed in almost any state at any session of the legislature.

The committee is of the opinion that the hospitals of the state should be in a position to act intelligently and effectively toward any proposed legislation or the rulings of any of the state boards affecting hospitals. In order that they can so act two things seem essential. One is the establishment of the already authorized legislative service bureau of the association. The other is the organization in each commonwealth of a state hospital association as a geographical section of the American Hospital Association. The legislative service bureau can make available for the hospitals in any state the experiences of those in other states. Through a state association and only through such an organization can the hospitals of a state make use of such service on the part of the association and secure the hearing which they deserve when matters in which they are vitally concerned are receiving consideration by legislatures, city councils, state boards and other public bodies.

The committee was continued until it can make its final report to the trustees of the association.

Contest for Plans of Small Hospital

The session closed with an announcement that The Modern Hospital Publishing Co. Inc., will hold an architectural competition for the plans of small hospitals and that prizes in the amount of $1,000 will be awarded to three contestants whose plans are adjudged to be the best.

A complete program of this competition will be found on page 313 of this issue.

Flooring Report Highly Praised

The scientific evaluation of flooring materials made by Mr. F. E. Chapman, director of Mount Sinai Hospital, Cleveland, in the report of his committee on floors was most warmly commended, following its presentation on Monday evening. Throughout that day and during the entire convention, Mr. Chapman's exhibit of flooring samples in the exposition hall was the object of close study and considerable comment. At a suggestion from the convention floor these samples will be retained and Mr. Chapman's committee will extend its work throughout the coming year, adding new samples which have been given his laboratory test.

The report presented is abstracted with some fullness on page 319 of this issue.

Interesting discussion followed the reading of the report. In commenting upon it Edward F. Stevens, Boston architect, said the report would be of great benefit to men of his profession in pointing out to superintendents the necessity of having the best possible floor regardless of the initial cost. Much, however, depends upon the care given any particular floor, in his opinion. In answering Mr. Stevens, Mr. Chapman declared he would put the emphasis rather on the method of laying the floor than the care given it.

"It is time," said Mr. Chapman, "to stop selling flooring material by the yard but to sell it by years of service. The place to sell a floor is not in the store but in the hospital."

Favorable comment on the report was made in subsequent discussion by Architects Charles Butler of New York, Perry W. Swern of Chicago, W. W. Rawson of Ogden, Utah, and C. F. Owsley of Youngstown, Ohio.

Mr. Swern suggested the advisability of drawing up standard specifications for the flooring samples, as a method of avoiding samples not representative of the usual run of the product. This followed Mr. Chapman's frank admission that he believed the terrazzo samples in his exhibit were of a higher grade and stood the tests better than this type of flooring often does in actual operation.

Champions of terrazzo who testified in its behalf were E. S. Gilmore of Wesley Memorial Hospital, Chicago, and the superintendent of a Memphis institution. The concensus of opinion was the terrazzo would crack under wear unless it was laid in squares with brass strips.

The wooden floor, cognizance of which was not taken in the report owing to the unreliability of samples, was warmly defended by Architect Owsley. Mr. Chapman unqualifiedly condemned wooden floors for any general use because, he said, they are not fireproof and frequent resurfacing prevents their constant availability.

Dr. R. G. Brodrick is the new third vice-president. He thought Atlantic City too distant from California and was present in spirit only.

In calling the section on construction to order, the chairman, E. S. Gilmore, outlined some of the considerations to be made in planning the modern hospital; among them were economy, site, fire protection, beauty of architecture, space for laboratory, provision for expansion and comfort for patients, doctors and nurses.

Dr. S. S. Goldwater as chairman of the committee on buildings—construction, equipment and maintenance—presented a comprehensive report on present tendencies and practices in that field. His enumeration of current practices showed some decided changes in emphasis in many departments and structural features of the hospital. The full report of his committee will be found on page 327.

A question box on construction concluded the first evening's program and although the queries submitted touched on a variety of practical subjects, many of them went begging for an answer. In explanation of this at the conclusion of the program, Dr. Goldwater stated that all construction questions must be decided for each particular hospital, their determination resting upon the analysis of conditions peculiar to that single situation.

Advice was sought by the questioners on the proper location of kitchen, pathological laboratories, x-ray laboratories, operating room, on the price of fireproof and semi-fireproof construction and a variety of practical subjects.

As to color of operating room walls, the statement of C. J. Cumming of the Tacoma (Wash.) General Hospital that a pale gray best served his institution went unchallenged. Dr. Zulich of Easton, Pa. declared that the pathological laboratory should be near the operating room for purposes of hasty examination. Mr. Swern, Chicago architect, furnished the information that it costs 56 cents per cubic foot for fireproof construction in Chicago; in Wisconsin he had found the cost as low as 50 cents. Mr. Lewis, architect of New York, declared small wards, arranged for easy communication with the sink rooms, were preferable to large wards, this arrangement providing the efficiency of ward treatment with the privacy of the private room. Dr. Goldwater expressed the opinion that when the out-patient service of a hospital is large, the x-ray laboratory should not be placed on the operating floor, thus bringing dispensary patients who are large patrons of the x-ray laboratory near the surgical suite. The consensus of opinion seemed to be that blanket warmers should be provided for each ward, although not many of the superintendents expressed themselves as having such an arrangement.

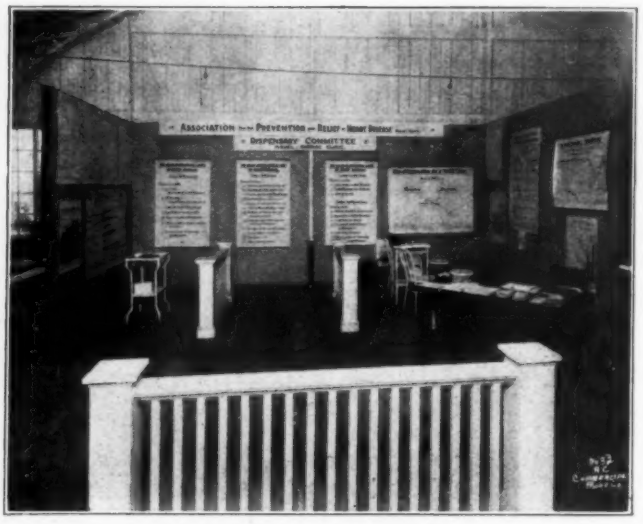
Thus went the round table on construction, with no answers more than suggestions and most remarks qualified by the statement that the principle could not be applied universally.

Dr. Baldy Explains State Venture

The second day's session opened with an account of Pennsylvania's system of checking up hospitals which receive state aid, presented by Dr. John M. Baldy, director of the Pennsylvania department of public welfare and author of the scheme. Dr. Baldy declares that the end of the first year's trial of this control will see the saving of hundreds of thousands of dollars of state funds.

"To get the fakers" is the primary purpose of this elaborate and minutely worked out scheme for checking up the charity work of Pennsylvania hospitals. In common with most hospitals, Dr. Baldy declared, the institutions of

Studies in out-patient service were graphically illustrated in the exhibit of the Committee on Dispensary Development of New York. Photographs of Cornell Clinic, tabulated material on dispensary service and other interesting charts were on display.



Where the model cardiac clinics were held each day. These were under the direction of the Association for the Prevention and Relief of Heart Disease of New York City. Charts and statistical data decorated the booth.

that state were loaded down with free patients who should not have been objects of strict charity. With the new system, with its triple function of accounting, credit and audit, the welfare department hopes not only to deny the use of state funds to those who do not need charity but to place worthy persons, who have too much pride to admit their poverty, in free beds without humiliating them.

Credit Department Makes Hospital Pay

"At the end of the year," said Dr. Baldy, "our state will know just what it costs to maintain a poor adult in a hospital. By installing this basic bookkeeping system, an essential to any business, in each hospital receiving state aid, the welfare department and hospital superintendents can tell at a glance what every department and every subdivision of each institution costs. Already the per capita cost of maintaining a poor patient has dropped and several institutions have so lowered their costs that they can meet expenses without state assistance. It has shown that scientific departments can be made to pay and that the hospital with a credit department, properly run, can soon be on Easy Street."

More Patients Pay Their Way

Commenting on Dr. Baldy's address, Mr. Frederick D. Green, secretary of the United Hospital Fund of New York, pointed out that ten years ago 38 per cent of the hospitals were members of this fund, while in 1920 the percentage was reduced to twenty per cent, and that whereas ten years ago 18 per cent of the patients paid all or part of the hospital charges, in 1921 45 per cent paid part or all of these charges, with the result that funds were released for other needy cases and reduced the burden of the taxpayer.

Mr. Franke E. Brooke, superintendent of the Harrisburg hospital, stated that it was his practice to tell patients at the outset what was in store for them as to the payment of their bills and also pointed out the desirability in compensation cases of taking up the hospital's claim personally with the business concerns involved.

Following this discussion the delegates adjourned to the moving picture theatre to witness two films on physiotherapy and occupational therapy presented by Dr. Chris. M. Sampson of the United States Public Health Service.

Dr. Harold W. Hersey presented the report of the committee on general furnishings and supplies, with the recommendation that the standardization of such equipment be carried to the greatest practical degree. His committee discussed tendencies and the more recent practices in the selection of beds, metal and wooden furniture, mattresses, pillows, casters and linens. No opposition developed to any of the recommendations of the committee and President O'Hanlon's call for discussion brought no delegate to his feet. The report is printed in full on page 334.

Dispensary Section Lively

Interest never waned at the section on dispensaries Tuesday afternoon. Mr. John E. Ransom, superintendent of the Michael Reese Dispensary, Chicago, occupied the chair and announced as the major topic for Discussion, "The Educational Value of the Out-Patient Department." Dr. John M. Dodson, dean of Rush Medical College, Chicago, in a forceful paper considered the theme from the standpoint of the medical student, intern and practitioner of medicine. In the absence of Dr. Haven Emerson, professor of hygiene and public health at Columbia University, New York, the chairman read his treatment of the topic from the angle of the patient and the community.

The dispensary's value in modern medical education is given high value by Dean Dodson who considers the out-patient department the best place for medical instruction because: (1) the student can get the clinical history of the ambulant patient more easily than he can that of the hospital patient; (2) the dispensary patient can be more readily and more extensively examined; (3) the student meets the patient in the incipiency of his illness and therefore can learn methods of prevention; (4) he is able to absorb technique of the social worker in ascertaining the family condition; and (5) he may see the convergence of many specialized lines of treatment.

From the standpoint of the practitioner the dispensary offers superb material for true graduate study; to a limited number of doctors it offers opportunities for specialization; and most important, in Dean Dodson's opinion, it is a place for the family practitioner to "brush up."

"We are facing a serious dearth of interns," said Dean

Dodson. "Medical schools cannot turn out enough students to supply the demands of hospitals for interns without flooding the country with physicians. The solution to this problem, I believe, is in resident intern service from practitioners in the vicinity."

The Family Doctor as Intern

"The family doctor could come into the hospital for from three to six months to the great benefit of his own practice and to the immense service of the hospital to its community. With good literature and laboratory facilities there is not a hospital of 100 beds in the country that cannot become a teaching hospital."

Some defects of present dispensary arrangements as Dean Dodson views them he enumerated as follows:

(1) The practice of assigning the duty of distributing dispensary patients to a non-medical person. All cases first should be referred to a doctor of general medicine for a complete examination. He should refer the case to a specialist only when it requires expert attention. Group practice of specialists can be thoroughly vicious unless there is some one to see that the patient gets a general examination first.

(2) There are some grounds for the contention regarding the exclusion from the dispensary of those that can afford to pay. Such practices tend to pauperize the community.

(3) The failure to use the out-patient department for teaching the general practitioner.

(4) The unfair arrangement of the work of medical students. The dispensary offers advantages in general medicine for both the beginner and the advanced student, and the junior student gets his best training in clinical records for the dispensary.

(5) Contrary to present practice, the dispensary is the place of all others to teach preventive medicine. Medical practice of the future lies largely in this field. The physician must be not only the family doctor but the family health adviser. The dispensary offers the physician a source of income which he needs, but he has hitherto given his services gratis. If the medical profession does not take up preventive work, somebody else will for the public is coming to demand it.

(6) There will be no effective public health service unless physicians intelligently cooperate with the public health officers. This entails a complete change of attitude on the part of the teachers of clinical medicine to get the social and public health viewpoint of each case.

In the discussion which followed the paper, a representative of Jersey City Hospital said that the out-patient department in his belief is apt to be rather careless about the selection of its staff. Michael M. Davis, Jr., of the Committee on Dispensary Development, New York, sketched the activities of the Cornell pay clinic. It was the opinion of Dr. Castleman of New Jersey that the staffs of small town hospitals are not equipped to teach the practitioners, being not so far advanced as their city brothers. Dean Dodson attributed this fact to the lack of stimulus to progress among country doctors because they did no teaching. Richard P. Borden, trustee of Union Hospital, Fall River, Mass., lamented the physicians' neglect of the great field for observation and education which the dispensary affords. That specialists would not care to accept the diagnoses of general medical men in group practice was the opinion of Dr. May of Washington, D. C.

Stage Set for Health Teaching

Dr. Emerson's paper in discussing the educational value of the dispensary to the patient and community read in part:

"We doctors, nurses, administrators and social workers are so intent upon our own professional job at the dispensary that we forget that what we are about is some kind of doctoring, and that doctoring is a good Latin equivalent for teaching. All the ingredients are ready at hand,—the person, or even better the persons, groups of them bound together by common interest in the most democratic of all things, disease; the state of mind essential for learning, created by desire to avoid further suffering or hope of return to health; a trustfulness and faith in the teachers that is one of the elements of pedagogic inspiration; the place; the time; and what is more important than anything except the pupil, something urgent to be taught, a matter of life and death, a matter of pain or blissful sleep, a problem of salvaging a family or losing the home.

"The dispensary as a place of public assembly where the audience selects for itself particular objectives might, in a most elementary form, offer instruction by printed word and painted lesson, by raising a smile or rousing curiosity, while the waiting sufferers sit fac-

The Child Health Railroad in the exhibit of the Atlantic County Committee of the New Jersey Tuberculosis League attracted many interested visitors.

Interesting statistical material on hospital service was furnished delegates at the booth of the Hospital Information Bureau of the United Hospital Fund of New York.

Father C. B. Moulinier, the guiding spirit of the Catholic Hospital Association, was active at Atlantic City.

ing the wall. In its logical suitable development, this simple teaching by bill poster or advertising sign could be expanded to include a beguiling entertainer whose business it will be to pick up the patient on admission and keep him or her, young or old, thinking and asking questions up to the moment of escape into the examining or treatment room."

Dietetic Section of Value

Two worth-while papers and an unanticipated report made up an eminently worth while session of dietitians on Tuesday afternoon. Miss Lulu G. Graves, supervising dietitian at Mount Sinai Hospital, New York, presided over the section on dietetics.

To the benefit of the dietitians but to the dismay of the general convention attendants, the report on food and food equipment, prepared by one of the exposition committees, was read at this section. No previous announcement of this change of program was made, so that many superintendents who wished to hear the report were denied that privilege. Dr. C. W. Munger of the Blodgett Memorial Hospital, chairman of the committee, presented the report, an abstract of which will be found on page 329 of this issue.

In the opening paper at this section Dr. Frank Howard Richardson, children's department, Brooklyn Hospital, Brooklyn, N. Y. dealt in detail with the subject of the relation of the hospital to children, putting forward suggestions for solving the problems of this aspect of the hospital. He laid emphasis on the desirability of reducing the time spent by the child in the hospital and treated also the subject of his proper feeding while there.

Children's hospitals, said Dr. Richardson, have yet to justify their existence; they are still on trial. Startling statistics, gathered from institutions for the care of children, show there a heavy mortality rate among children who stay for any length of time. The pros and cons for the hospital care of children are pretty evenly balanced but the appalling death rate noticeable in even the best regulated infant's wards, the danger of cross infection, the hardship of separation felt by both parents and children and the undesirable mental effect upon the child of the sights and sounds of a hospital, these and other drawbacks present a real problem. The way out seems to be the out-patient pediatric department, and this agency, with its logical appendage, the nutrition and health class, should be utilized to its fullest extent, and can be developed in many directions.

With regard to the feeding of infants Dr. Richardson feels there has of late been healthy reaction from the old time elaborate milk formulas to what are known as "simple dilutions." The extreme importance of the care of milk, this product so highly perishable and so easily contaminated, has come to be widely realized. The only milk fit to be given to an infant or a child is pure, fresh unaltered cow's milk and the only milk that conforms to these simple and minimum requirements in our cities is certified milk.

In her paper, entitled "The Relation of the Department of Dietetics to the Hospital Composite," Miss Marion Peterson, supervisor of administration in the department of dietetics, Lakeside Hospital, Cleveland, suggested a variety of ways in which the department of dietetics may contribute its share toward the general usefulness of the hospital, and dwelt on the interdependency of the different departments of the hospital.

Variety the Dietitian's Watchword

The dietition's responsibility for the three meals a day, said Miss Peterson, gives her a unique point of contact with every individual in the hospital and therein lies her great opportunity. In planning meals variety should be the dietitian's watchword, for institutional food so readily becomes monotonous, and she should ever remember the special needs of doctors and nurses detained late in operating room or ward and see that their food is hot and freshly prepared and does not consist of cold leftovers. By serving meals that satisfy she can aid

Two of the convention's busiest men were Dr. S. S. Goldwater and Dr. Otho F. Ball.

largely in preventing food waste. Dietitians should have opportunity to visit patients and thus learn their preferences and customs so that she may plan for them intelligently. Let her give the Italian spaghetti once in a while, the Scandinavian pickled herring, and win a contented patient and a friend for the hospital.

Miss Peterson pointed out that the dietitian should be a teacher as well as a provider; instruction should be given to the patient prior to his leaving the hospital and visits paid to his home afterwards to help there during the difficult period of readjustment. Recipes should be given out and guidance offered in the use of certain foods. Dietary supervision, supplementing medical care, may prevent in many cases the need of hospitalization and should be continued indefinitely. Work of this kind makes possible close cooperation between the dietitian and the social service worker and will be mutually beneficial.

The educational work of the dietitian extends beyond the instruction given to patients, for the teaching of pupil nurses holds an important place in her work. Doctors increasingly realize the soundness of dietotherapy and demand more and more knowledge of this subject from their nurses. Intensive dietetic training for pupil nurses will be possible of course only where there is a full time instructor in the diet kitchen. In some hospitals the interns also are given instruction in practical dietetics to supplement the theoretical knowledge they receive during their training. There are also the student dietitians who must depend so much upon what they can derive from their course of apprenticeship. The department of dietetics should be maintained with the finest possible organization in order that these students may receive the right sort of background.

Fears Excess in Standardization

Dr. George D. Stewart, president of the New York Academy of Medicine, in an entertaining address opened the general session on Tuesday evening. His subject was "Standardization Values" and he sounded early warning that he did not set too high an estimate on that practice which has lately become the cry of the hour.

"Nowadays," began Dr. Stewart, "we standardize everything from ship building and hospital administration to birth control and control of appetites. Standardization is largely begotten of our economic necessities and sometimes it leaves out all other considerations. It is a recognition of the fact that we have exploited our natural resources and if carried to excess hinders progress.

"The standardization of medicine and of hospital management may result in much good or in great danger. The easiest way to settle down into a rut is to standardize. I have even heard of one hospital superintendent who issued typewritten directions for its staff members to follow in performing an operation. I deplore the attempt to make me do a thing a given way, if I can do it a better way.

"Standardized histories in the hospital can constitute a source of great error, if made by one man and filled in by another. In my opinion the histories should be made by the man himself and interpreted by him. Collectivism and standardization lead toward communism and in communism individuality is relinquished entirely."

Dr. O'Hanlon (right), retiring president; H. E. Webster (center), a former vice-president; and an exhibitor.

Dr. and Mrs. Stephens strolling down the Boardwalk, with a Canadian confrere, Dr. Haywood.

Recommends Mutual Liability Insurance

One of the most worthwhile papers of the convention was that of Mr. John A. Lapp of the National Catholic Welfare Council on "The Liability of the Hospital." Mr. Lapp, a graduate in law and a close student of hospital and health problems, has during the past year made a comprehensive survey of recent legislation affecting the liability of hospitals.

"The hospital should not get alarmed about its legal liability," Mr. Lapp asserted after citing several cases in which high courts had fixed responsibility upon hospitals. "The liability of a properly run hospital is very slight. Liability may force upon trustees and managers greater attention to the trust which has been imposed upon them, but if their duties are properly performed there is slight cause for fear. On the other hand, a hospital which is not properly run, a hospital which has a reputation for slovenly work and unsanitary conditions, may well look to its liability."

Mr. Lapp was of the opinion that charitable hospitals should insure against liability but not at exorbitant rates. Since liability is slight in the average well-managed hospital, rates of insurance should be extremely low. He suggested that a hospital mutual insurance company operated at cost by the hospitals themselves would be a satisfactory way to handle that situation.

Before the program was concluded, President O'Hanlon called upon Bird S. Coler, commissioner of public welfare of the city of New York, for some impromptu remarks. The commissioner told something of New York's hope to become the world's center of medical

teaching, and something of its present hospital facilities which he characterized as entirely adequate.

Trustees Hold First Meeting

Wednesday morning was signalized by the first meeting of the association's section on trustees, of which Mr. Arthur A. Fleisher, president of the Jewish Hospital of Philadelphia, was chairman and Mr. Henry C. Wright of New York secretary.

The meeting was opened by Dr. O'Hanlon, president of the association, who asserted that this section should have been one of the first sections of the association, inasmuch as trustees should know about the hospital in all its aspects.

The section did not have a set program, but devoted the morning to an informal discussion of a number of suggestive topics. The first topic was the kind of reports which superintendents should make to their boards of trustees. One delegate thought the report should cover: (1) The financial condition of the institution, showing its general expenses and the per diem cost per patient; (2) the activities of the different departments and (3) the needs of the hospital, pointing out the defects and making such suggestions as will enable the board of trustees to act intelligently.

Mr. Henry C. Wright of New York pointed out that the kind of report made by the superintendent will depend to some extent on what the trustees regard as their functions. If certain of these functions are delegated to committees they should report directly to the board.

Mr. W. W. Rawson, superintendent of Thomas D. Dee Memorial Hospital, Ogden, Utah, felt that committees of the board of trustees should discuss their action with the superintendent of the hospital and let him incorporate their views in his report. In this view Mr. Rawson was supported by Mr. Daniel D. Test, superintendent of the Pennsylvania Hospital of Philadelphia.

Mr. Henry C. Wright pointed out that two things that often cause great trouble in the hospitals are the incompetency of the superintendent and the interference by members of the board of trustees in administering the details of the hospital; he made a plea for the assignment of particular zones of action and function to both superintendent and trustee.

President and secretary of the newly created section on trustees, Mr. Arthur Fleischer (right) and Henry C. Wright (left).

Mr. Richard P. Borden Union Hospital, Fall River, Mass. stated that since the hospital exists primarily for the benefit of the patient, the superintendent should report to the board of trustees all action taken by the hospital regarding patients. No single trustee in his opinion should act as an intermediary between the board as a whole and the hospital. This should be the function of the superintendent. Special committees of the board should always act in consultation with the superintendent. Committees may investigate special subjects, but usually cannot do so successfully without using the knowledge which the superintendent has on the question.

Mr. Frank E. Brooke, superintendent of the Harrisburg Hospital of Harrisburg, Pa., stated that his board of trustees, has a system of functioning committees, consisting of a finance committee, a medical committee, a supply committee and a property committee. These committees meet previous to the monthly meeting of the board, and the superintendent sits at each of these committees and at the meeting of the full board. The superintendent conducts the meetings of the committees, who are required to thresh out details and present written reports at the regular monthly meetings of the entire board. In this way the plans and ideas of the superintendent are presented to the board through its committees.

Mr. Thomas Zulick, superintendent of the Paterson Hospital, Paterson, N. J., said that in his institution the superintendent reports the financial and other conditions of the hospital, the work of the staff and whatever actions may be taken at the staff meetings.

Discussing the question of how trustees can best keep in touch with the work of the institution, Mr. Rawson of Ogden, Utah, pointed out that in his institution they have an advisory committee of physicians which meets with the committee of trustees and the superintendent once a month. There is also a meeting of the trustees on nursing, which meets once a month with the nurses.

Mr. Henry C. Wright described the plan which the trustees of Bellevue Hospital recently adopted for expediting its business and an agenda of each meeting of the trustees is mailed to reach the trustees two days in advance. After the superintendent submits his report, the chairman of the board asks the trustees present whether they desire to reserve any of the items of the agenda for discussion; those not reserved are then passed upon as a whole with the recommendation of the superintendent.

Satisfied Patients Best Publicity

The second question related to the kind of publicity hospitals should undertake. Mr. E. S. Gilmore of Wesley Memorial Hospital, Chicago, felt that the best publicity was a well treated patient. For special purposes, such as raising funds for a new building, he recommended the employing of a publicity expert.

Mr. Brooke of Harrisburg, said when he first went to that city he invited the editors of local newspapers, together with the reporters assigned to the hospitals, to meet him personally. Through this personal contact he has been able to secure the kind of publicity he desires.

Dr. Charles E. Ide, superintendent of Muirdale Sanatorium, Wauwatosa, Wis., described an interesting experiment under which the newspapers were given an idea of the hospital and its work through a committee of patients.

Speaking of the question of how the public should be appealed to for funds, Mr. Borden of Fall River, Mass., held that this was a difficult problem and it was not possible to establish any definite way that would be adaptable to all communities.

A further question discussed was what constitutes hospital policy. Discussing this subject, Mr. Wright stated that trustees must do two things, they must determine policies and hold themselves to them; and also determine

SOME RIDE AND SOME STRIDE AT THE FAMOUS OCEAN RESORT

what reports mean. Policy must be distinguished from procedure.

Protest Collateral Inheritance Tax

Discussing the question of whether hospitals under private management should receive state funds, Mr. Charles Ford, director of the activities of New York State Board of Charities, stated that some time ago New York abandoned state aid and adopted the policy of local aid. The hospital charge becomes a matter of agreement between the locality and the hospital in that locality. The amount paid by the locality is generally higher than the hospital could expect from the state and in many instances it approximates the cost of maintenance.

Mr. Borden of Fall River urged that trustees should now further the work of the American Hospital Association by becoming institutional members and thus providing the Association with necessary funds.

The session closed with the adoption of the following resolution: Resolved, That the division of portions of legacies to hospitals, homes or other charitable or religious organizations for state purposes, through the means of a collateral inheritance tax or in any other manner is such a harmful and detrimental procedure, that the trustees section of the American Hospital Association desires to place itself upon record as being opposed to any such method of taxation.

Nursing Section Is Profitable

Wednesday's program yielded a succession of reports far-reaching in their scope and in their future. At the morning section on nursing was discussed with intelligent criticism the report on nursing education, that forward-looking document prepared under the auspices of the Rockefeller Foundation. The section on administration in the afternoon centered its program around the report on the training of hospital executives. In the evening before the social service section, Mr. Michael M. Davis, Jr., presented the findings of his committee on training for hospital social work.

Miss Amy R. Hilliard, R.N., superintendent of Samaritan Hospital, Troy, N. Y., opened up the discussion of the nursing education report, as the section was called to order by its chairman, Miss Laura R. Logan, superintendent of nurses at Cincinnati General Hospital.

To the report's conclusions regarding additional training for public health nurses, Miss Hilliard thought all nurses would subscribe. She called attention to the "sham courses" in public health nursing being conducted in Chicago by a former commissioner of health and declared that it passes understanding that any hospital would employ one of these workers.

"The scope of nursing schools must broaden to the level of other schools of higher education," said Miss Hilliard. "For such an exacting professional career the background should equal those of colleges. We must lend our efforts to obtain the endowment of schools of nursing. The public is so accustomed to consider the nurse as an obedient servant that it does not see her as a financial obligation. Further we must see to it that administrators and supervisors of nursing schools are not recruited from the inexperienced and unprepared. They must have the definite educational preparation required for executives in any other professional school. And we must all work toward national standards for licensure of persons of any grade who have as their profession the care of the sick."

Chief interest among nurses today undoubtedly centers about ward helpers or attendants. Miss S. Lillian Clayton, R.N., director of nursing at Philadelphia General Hosptial, in presenting an able paper on "The Use of Ward Helpers," opened up this fertile field of discussion.

Attendants of Real But Limited Value

Miss Clayton defines ward maids as those persons employed in the hospital for housekeeping purposes who have had no previous training or answer no educational requirements. Ward helpers, according to her classification, are persons of greater intelligence but possessing no educational standards beyond the ability to speak and write English. They are workers, not learners, and their position is in no way to be considered as experience in the care of sick. Ward attendants, as she defines them, are grammar school graduates to whom the hospital furnishes maintenance, uniforms and a small allowance, and to whom is given careful preparatory training of eight or nine months at the end of which they receive a certificate.

In introducing any of these groups in the hospital, that institution should first be satisfied that it can train them without exploitation, Miss Clayton asserts. Any hospital should refuse to conduct such a course unless the training can be given in perfect fairness to the workers, the public and the hospital.

Four recommendations were made by Miss Clayton regarding attendants: (1) The hospital should not employ more than are needed for actual work; (2) The patient should not be subjected to their care when critically ill; (3) the hospital should have as satisfactory a reputation for its attendants' schools as for its school of nursing; and (4) the hospital should refuse to train attendants until legislation makes it impossible for physicians and the public to employ them as full grade nurses.

THE MODERN HOSPITAL booth served as a general information office and conference room for delegates, as well as fulfilling its educational and promotional functions.

"There is no question as to the attendant's value," said Miss Clayton, "but her value is limited. The American Hospital Association and the nursing organizations should unite their efforts until this present problem of the attendant is worked out satisfactorily."

A spirited discussion of the report and of Miss Clayton's paper followed.

Miss Mary A. McMillan, superintendent of the School of Nursing at Presbyterian Hospital, Chicago, believes that the twenty-eight month course recommended in the report is too short in most instances. She suggested

that some hospitals give that length of course but that others be allowed to continue the full three years of work so that the student could select the course she desired.

That the twenty-eight month course is an experiment well worth trying is the opinion expressed by Miss Elizabeth A. Greener, director of nurses at Mount Sinai Hospital, New York. The purpose of the shortened course is to relieve the student from unnecessary, non-professional duties, said Miss Greener, and many of these can well be spared.

Miss Elsie M. Lawler of Johns Hopkins Hospital, Baltimore, believes that twenty-eight months are not sufficient for training unless the course is properly safeguarded.

The duty of nurses, as seen by Miss Jane M. Pindell of Franklin Square Hospital, Baltimore, is to arouse public sentiment toward the appropriation of funds for additional high school facilities so that nursing students may meet the higher requirement for admission.

Miss Minnie Goodnow of Children's Hospital, Washington, D. C. cited figures to show that one out of every six graduates of high schools must enter nursing training schools if the demand is to be met. The only way to provide sufficient care for the sick lies in the training of a group of attendants, she believes.

Nursing students and nursing attendants should not be trained in the same hospital in the opinion of Miss Rose Van Wort, superintendent of the Stuart Circle Hospital, Richmond, Va. She related to the convention some details of the Virginia plan of training attendants, which includes the provision of a patented separate uniform for nursing attendants to prevent them representing themselves as graduates of regular training schools.

There was always a crowd of information seekers at the exhibit of the Hospital Library and Service Bureau.

Superintendent Steffen of a Columbus (Ohio) hospital, declared that attendants will represent themselves as graduates and nothing can be done to prevent it. He would be most reluctant, he said, to give courses for the two grades of nurses in the same school. A superintendent of a small hospital, Miss Burns, contributed to the discussion by saying that the small hospital is no place to give a short course.

Dr. Ernst P. Boas, head of Montefiore Hospital for Chronic Diseases, New York, agreed that it was impossible to control the graduates of short courses after they leave the institution. In spite of legislation in his state, he declared, short-term nurses are now practicing as full-term graduates. In a large city the best type of woman is not attracted by the short courses, in his judgment.

The nursing section contributed to the convention one of its strongest papers in Miss Annie W. Goodrich's presentation of the role of the hospital in the community health program. Miss Goodrich is director of nursing at Henry Street Settlement, New York.

"The hospital's duty," Miss Goodrich explained, "is to function either as a health center in a given area or as a link in health activities. To bring this about means the reconstruction of the entire hospital program, method and system. The hospital must figure in preventive rather than curative medicine.

"The unit of hospital responsibility in the new program will be the family, not the patient. The hospital must assume its obligation to the public and to its own personnel. It is necessary that the intern be provided with recreation and a healthful routine, for long hours and overwork on his part will react disastrously on the patient. In cooperation with health and social agencies the hospital is agonizingly slow and intolerably aloof, but the tendency is growing."

Gauze Reclamation a Success

Dr. A. B. Denison's report on the renovation of gauze and standard dressings took up the early afternoon hours on Wednesday. The committee's method and findings are contained in an abstract of the report on page 328 of this issue.

Massachusetts General Hospital was the first institution to inaugurate the practice of washing gauze, and Dr. Frederic A. Washburn recalled its early efforts in that direction in the discussion which followed the report. This institution tested the life of the gauze on one occasion by running a black thread through any given piece each time it was washed. Some of the pieces were washed as many as twelve or thirteen times, it was learned.

Daniel D. Test, superintendent of Philadelphia General Hospital, another pioneer in reclaiming gauze declared that $90,000 has been saved his institution by that means. The necessary apparatus for its reclamation cost $750.

Rappleye Reviews Report

The section on administration concerned itself almost wholly with the recently completed report of the committee on the training of hospital executives. Dr. Willard C. Rappleye, executive secretary of the committee, himself was on hand to present the report. The convention later approved it, after full and free discussion had been engaged in.

In reviewing the report, Dr. Rappleye commented upon the growing philosophy of community responsibility which hospital executives are developing. The hospital occupies a strategic position in the field of health, he declared, the common ground about which can be mobilized the various agencies of health promotion. For this enlarged responsibility is needed an executive of a broad vision of service. It is this type of administrative officer which the suggested course of study hopes to turn out.

Dr. Rappleye's committee views as preliminary requirements for the course suggested maturity, education and an indication of executive ability.

Congratulations were offered the committee by Dr. Winford H. Smith, superintendent of John Hopkins Hospital, on its definition of the future hospital function. The difficulty in its realization, as he sees it, is in at-

tracting the right type of persons into the work. To get proper executive material, he thinks, there must be a broadened field of usefulness and in the way of this broadened field stands: (1) the acute opposition of the medical profession to view community medical problems through organizations rather than individuals; (2) the lack of interest on the part of medical men in executive work as a career; (3) the difficulty in getting men and women to enter such a training course.

"We won't get men and women to take up this training course," he declared, "until we get a recognition

The American Library Association arranged an attractive booth in Exposition Hall with a suggestive exhibit of a hospital library. Scenes in the libraries of army, navy and public health service hospitals decorated with walls, and posters and charts showed graphically the extent and possibilities of library service in institutions which house and care for the sick.

from the medical profession, hospital boards of trustees and the community that it is a career of essential value to the working out of the health problems of the community. To offer a course in administration at present will not yield the type of men we want. Our best hope in this connection would be the inauguration of the course in an institution where there exists a well organized school of public health."

Must Catch Them Young, Says Washburn

Quite of another opinion was Dr. Washburn of the Massachusetts General Hospital.

"It isn't necessary to broaden the field," he brought out, "but the difficulty in getting the right class of men lies in the fact that we don't catch them young enough. If medical schools would place emphasis on hospital administration as a career, the problem would be more readily solved."

Dr. Washburn expressed his personal approval of the report and said in his judgment it possesses sufficient force to induce some university or foundation to take it up.

To Dr. Rappleye's trio of requirements for entering the course, Mr. Test of Philadelphia General Hospital, would add another three: character, temperament and "horse-sense." Mr. Test asserted that the committee has made an excellent start and the convention should get behind the report.

Dean John M. Dodson of Rush Medical College, Chicago, contributed the opinion that if hospital executives are properly trained, officials will make the career attractive, financially and otherwise. He suggested that at first some fellowships should be offered as special inducements to enter the course.

"Medical schools in the past have been neglectful in emphasizing the possibilities in administration," Dean Dodson stated. "They must face a complete reorganization: (1) to emphasize the preventive side of medicine in which the hospital is a health center; and (2) to have regard for other avenues of activity than that of the practitioner, among them the hospital superintendent."

John R. Howard of the New York Nursery and Child's Hospital entered the discussion by declaring the report 100 years ahead of the times. It will be necessary to educate hospital trustees as well as hospital executives to this new vision of the hospital's function, he added. To run a hospital and to organize a community health service takes two entirely different types of mind, in Mr. Howard's opinion, and he thinks the report expects the impossible. He further criticized the suggested curriculum on the grounds that it will not train a man as an executive of a metropolitan hospital.

Edwin R. Embree, secretary of the Rockefeller foundation, was present at the session and in a brief talk sketched hospital conditions in the Orient from which he recently has returned. The whole background of health appreciation in the Orient has been laid by the hospitals, he declared. It was the mission hospital which first led the Chinese to appreciate the importance of means of controlling disease.

Hospital Social Workers' Section

Wednesday evening's program, following the transaction of a small amount of general business, was largely devoted to the section on social service of which Miss M. Antoinette Cannon was a most gracious chairman.

William H. Matthews, director of the Family Welfare Association for Improving the Condition of the Poor in New York, opened the section program with an address on "What Social Service in its Hospitals Means to a Community."

"Sickness is the chief recruiting sergeant for relief agencies," said Mr. Matthews, "and the hospital social service worker can be a positive constructive factor in the institution. The hospital and dispensary cannot give the best kind of service to their patients when they have to be rushed through subway-turnstile fashion. Here lies the province of the social worker—to take the patient immediately following the physician's pronouncement of his ill and reassure him that his family and himself need not suffer during his treatment and convalescence." Mr. Matthews cited several situations where the social worker was the saviour of morale and the essential factor in rehabilitation.

Dr. Charles A. Drew, medical superintendent at Worcester City Hospital, takes a stroll.

The thorough and significant report of the committee on the training of hospital executives, just

completed, was then presented to the convention in abridged form by its chairman, Michael M. Davis Jr. The report was enthusiastically received and warmly commented upon in subsequent discussion. An abstract of it in some comprehensiveness will be found on page 322 of this issue.

John L. Montgomery, executive secretary of the Monmouth County (N. J.) Organization of Social Service, sketched some of the many services that association furnishes a mixed urban and rural community. Travelling mental hygiene clinics, travelling dental clinics for rural school children, county appropriations for the poor, demonstration psychiatric clinics in the hospitals and numerous other constructive health measures are being carried on by this organization in cooperation with Monmouth Memorial and Ann May Memorial Hospitals and the county sanitorium. The schools and hospitals are in close cooperation in providing these services.

Another interesting accomplishment in the field was described by Miss Mary Tobin, director of social work at the Neurological Institute in New York. It is social work with problem children and has already a splendid showing in assisting children of from two to eighteen years in making social adaptations. Not less important than the work with children is the concurrent education of parents. A successful phase of the work is the practice of taking all social histories in the children's homes. Then when the psychiatrist first sees the child, he has all the information regarding environment and general home conditions.

Experiences with the uneducated "mountain whites" of Kentucky in health and social work were related by Miss Annette Cowles, superintendent of Children's Free Hospital at Louisville in a short address. Miss Cowles stressed the need of social service and public health workers throughout the South and showed how her own small hospital has been a factor in teaching personal hygiene to the children and mothers of a degraded class.

No warmer praise of hospital social service work was spoken during the evening than that contributed by Oliver H. Bartine, hospital consultant of New York. Mr. Bartine stressed the importance of locating the social service department in hospital planning. The offices of this department should be centrally situated and in close proximity to the administrative offices. Desk room for the social service workers can then be provided in the outpatient department, but the social work of the entire hospital will be centralized.

The general session on Thursday morning was devoted to the report of the exposition committee on laundry equipment and supplies, which was read by its chairman, Dr. William P. Morrill, superintendent of Shreveport Charity Hospital, Shreveport, La., and to a paper by Dr. Willard C. Stoner of St. Luke's Hospital, Cleveland, Ohio, on the hospital problem in relation to modern medicine. This paper was originally read at the last meeting of the Methodist Hospitals and Homes Association and will be found in abstract in the March issue of THE MODERN HOSPITAL. There was no discussion of either paper.

The convention at its closing business session made three amendments to the constitution. One raises the dues of associate personal members from $2 to $3 a year. The second reads that "active personal members shall be those who at the time of their election are trustees or superintendents or assistant superintendents of hospitals, or members of medical staffs of hospitals, or executive officers of any organization having as its primary purpose the development of hospitals for general public service, the scope and nature of whose work is approved by the board of trustees. Any person once an active personal member may continue such membership as long as the rules of the association are conformed with." The third amendment increases the personnel of the membership committee from three to five members so that all natural Geographical Sections may be represented.

Edwin R. Embree, secretary of the Rockefeller Foundation, which gives ample evidence of its interest in the betterment of hospital service.

Mr. Richard P. Borden, chairman of the resolutions committee, moved that since many of the resolutions presented bore on questions of policy, not to be entered upon hurriedly, all consideration of them be postponed until the next annual conference. His motion was carried.

Announcement of the election results brought renewed interest in the theater. The only closely contested office was that of president for which Dr. Willis G. Neally of Brooklyn Hospital received 125 votes and Dr. Malcolm T. MacEachern of Vancouver General Hospital received 181.

Prolonged applause greeted Mr. Asa S. Bacon, the new president, as he took the chair and in a straightforward and sincere address pledged himself to his task. His speech of acceptance is printed in full on page 272 of this issue.

Mr. Bacon had his committee appointments already drawn up and these were read preceding adjournment. They are as follows:

Committee on Constitution and Rules

Richard P. Borden, trustee, Union Hospital Fall River, Mass.; George S. Hoff, secretary, Lake View Hospital, Danville, Ill.; John M. Peters, M.D., superintendent, Rhode Island Hospital, Providence, R. I.

Committee on Nomination

George F. Stephens, superintendent, General Hospital, Winnipeg, Canada.

Charles S. Woods, M.D., Indianapolis, Ind.

W. P. Morrill, M.D., superintendent, Shreveport Charity Hospital, Shreveport, La.

Lewis A. Sexton, M.D., superintendent, Hartford Hospital, Hartford, Conn.

C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash.

Committee on Membership

The Rev. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis.; Miss Margaret Cummings, superintendent, Buhl Hospital, Sharon, Pa.; Sister Geraldine, St. Elizabeth's Hospital, Youngstown, Ohio.

Committee on Out-Patient Work

Alec N. Thompson, M.D., director, Department of Medical Activities, American Social Hygiene Association, New York.

A. K. Haywood, M.D., superintendent, Montreal General Hospital, Montreal, Canada.

Walter Niles, M.D., dean, Cornell Medical College, Ithaca, N. Y.

BETWEEN SESSIONS DELEGATES PROMENADED ON BOARD WALK AND PIER

WIDE INTEREST IN ROUND TABLE SESSION

DELEGATES gradually have come to look to the round table as furnishing the real meat of the annual conference. This year their anticipation was proved not too high, for Mr. Asa S. Bacon, the King Arthur of hospital round tables, led a most varied and profitable discussion.

Acceleration of the general program, brought about by the desire of many in attendance to leave on evening trains crowded the general business session forward into the round table meeting and somewhat curtailed its scheduled program. A number of questions sent in were thus unanswered, but they with the replies will be included in the annual convention report, Mr. Bacon announced.

QUESTION 1. What percentage of the hospitals in the association allow osteopaths to care for patients in the hospital; and under what conditions, if any, are they allowed?

Dr. W. P. Morrill, Shreveport (Ala.) Hospital: By the questionnaire method the following figures were obtained in relation to the percentage of hospitals which allow osteopaths to care for their patients: 83⅓ per cent do not admit them; 11⅓ per cent admit them under the supervision of M.D.'s; three per cent permit them to practice independently.

Some extremely amusing and illuminating comments accompanying the questionnaire replies were read by Dr. Morrill. One institution admits osteopaths if the patient will sign a paper assuming full responsibility; another admits but "does not encourage" them; one writes, "They shall not pass."

QUESTION 2. (a) Where a nurse is trained in the giving of anesthetics and a death results directly from anesthesia, who is held legally responsible for this? (b) Can an institution chartered as "charitable, not for profit" be sued for such a mishap?

Dr. E. T. Olson, Englewood Hospital, Chicago: (a) As an employe of the hospital or the doctor, the nurse is an agent and they are responsible. Proven neglect of permission or omission of doctor or hospital would render either of them liable. If the anesthetist is working for a fee, she is subservient to the doctor. If ordinary care, skill and judgment are observed by the hospital or doctor, no judgment should be rendered the plaintiff.

(b) Any hospital or individual may be sued. Supreme courts of some states have held that no damages may be collected from charitable institutions on the grounds that it is an improper diversion of funds held in trust for other purposes. Other states differ.

Mr. Daniel D. Test, Philadelphia General Hospital: If all reasonable precautions are taken, recovery cannot be made, but any decision will be rendered on the merits of the case.

QUESTION 3. Should any other, except physicians, give anesthetics; for example, nurses?

Dr. Malcolm T. MacEachern, Vancouver (B. C.) General Hospital: The question of nurses giving anesthetics is a controversial subject and is dependent upon four factors: its medico-legal aspect, economy of service; efficiency of the anesthetic; and consideration of the patient. The best practice is to have a department of anesthesia with a medical man at the head and with the nurse as his technical assistant.

QUESTION 4. What is the duty of those in charge of the hospital when the patient under the care of an unethical doctor asks to be admitted to the hospital?

Dr. C. B. Hildreth, St. Luke's Hospital, Cleveland: The American College of Surgeons clearly defines it as the duty of those in charge to pass on information to the patient.

QUESTION 5. Is it advisable to have medical protective insurance for hospitals?

Mr. E. S. Gilmore, Wesley Memorial Hospital, Chicago: Any hospital is foolish if it does not have such insurance. Since it is the patient who creates the need for such protection, the expense should be defrayed by him. The insurance should be added to overhead, and the rates so adjusted as to cover it.

QUESTION 6. (a) Should the hospital staff be under the control of a chief, or president and executive committee?

(b) How many doctors ordinarily comprise a good staff; or, in other words, how many should be on the staff of a 250-bed hospital with an out-patient department?

(c) Should doctors who are active in the hospital proper (as staff members) also be on service in the out-patient department?

Dr. C. W. Munger, Blodgett Memorial Hospital, Grand Rapids, Mich.: (a) No hospital should be under the control of any one man. Every staff should have a presiding officer elected by the staff and approved by the trustees. Some times it is wise in a newly organized hospital to have the chief appointed by the trustees, but this should not be adopted as a policy.

(b) Although it is impossible to generalize, a study of a number of hospitals averaging 250 beds shows that there is one doctor for every five patients where charity work constitutes 30 per cent of the hospital practice.

(c) In my opinion the doctors who are active in the hospital proper should not also be on service in the out-patient department because these men have large private practices are too busy, and further because the younger men need the experience. The more mature doctors should be utilized as consultants.

QUESTION 7. In a small city of 10,000 inhabitants with a forty-bed hospital where all the doctors send their patients for treatment, what form of staff organization is most ideal?

The Rev. H. L. Fritschel, Milwaukee (Wis.) Hospital: All physicians in the community should form the staff with an executive committee to govern.

Exception to this answer was taken by Mr. Golden of West Virginia who said in his experience in a town of 10,000 better results are obtained by a staff appointed by the board of trustees.

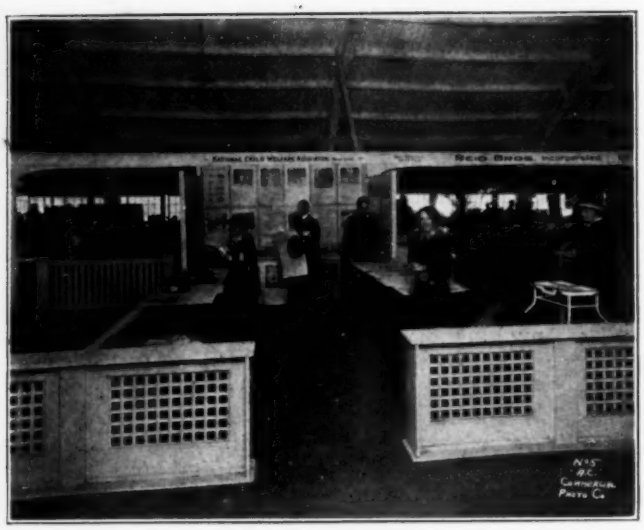
QUESTION 8. What is the proper attitude toward allowing visitors in the operating room during operations?

Mr. Paul H. Fesler, University Hospital, Oklahoma City, Okla.: Visitors should not be permitted in the operating room. In charity or clinical cases, this rule is more easily enforced, but with private cases it sometimes is necessary to use great effort.

Dr. E. T. Olson of Chicago said that no distinction is made in Chicago and that no lay visitors are permitted in the operating room during operations under any consideration.

QUESTION 9. Should the association make the daily programs longer or shorter?

Dr. Raymond G. Laub, Greenpoint Hospital, Brooklyn,



Wide attention was attracted by the educational panels worked out by the National Child Welfare Association on the various health phases of normal childhood.

N. Y.: It seems to be the consensus of opinion that the length of the night sessions should be reduced. Exhibitors say that they want the sessions to start promptly and to finish when it is announced they will.

QUESTION 10. Can post mortems be made without the consent of the authorities of the hospital and the relatives of the deceased?

Dr. E. R. Crew, treasurer, Ohio Hospital Association: To hold an autopsy without consent of the nearest of kin is a tort. Holdings of courts in various states differ.

One superintendent declared that the physician should refuse to sign the death certificate unless an autopsy was held; the matter should then be referred to a coroner who will order an autopsy.

Objection to this suggestion was made by a gentleman from Minnesota who said that in his state when a coroner steps in an inquest is necessary, and inquests are costly.

QUESTION 11. How many interns should a 200-bed hospital have?

Dr. Lewis A. Sexton, Hartford (Conn.) Hospital: This depends upon the type and assignment to duty. More are needed in a hospital with a teaching connection. A survey of 24 non-teaching hospitals averaging 200 beds showed the following results:

Two hospitals had two interns; two had three; three had four; two had five; five had six; one had seven; one had eight; one had nine; one had 10; two had 12; one had 16; one had 19; and one had 21.

Of these 20 hospitals have rotating service; 17 have twelve months' service; and 12 pay their interns. The average of those surveyed have one intern for each 27 patients. A more ideal number for a 200-bed institution would be eight interns.

QUESTION 12. Should the hospital, realizing that the patient is not receiving all the necessary treatment, and the patient's people feeling the same, permit the patient to change doctors while in the hospital?

Mr. Frank E. Chapman, Mount Sinai Hospital, Cleveland: That is up to the patient. It is within the province of the patient in the private pavilion to change doctors if he wishes. Since it is the hospital's duty to see that the charity patient get proper service, it is up to the hospital to see that he gets it.

The tongue of the wise is health.—Prov. XII:18.

IOWA SANATORIUM ASSOCIATION IS NEWLY ORGANIZED

Sanatorium officials of Iowa, to the number of sixteen, met Saturday, September 30, at the State Sanatorium at Oakdale. The purpose of the meeting was the formation of an association for the consideration of sanatorium problems. The Iowa Sanatorium Association was formed, with Dr. H. V. Scarborough, superintendent of State Sanatorium, as president. Miss Charlotte Garrison, superintendent of Sunny Crest Sanatorium, Dubuque, was named secretary. Topics of interest in the institutional treatment of tuberculosis were discussed, featuring rest and exercise, clinic development, etc. Inspection of the new building at Oakdale and observation of a pneumothorax completed the day.

Among those in attendance were Dr. John Peck, clinician and president, Iowa Tuberculosis Society, Des Moines, and Dr. J. W. Kime, legislator and superintendent, Bowlder Lodge Sanatorium, Fort Dodge; Miss Ellen Standing, superintendent, Sunny Slope Sanatorium, Ottumwa, had the distinction of presenting her full board of trustees, Mrs. W. C. Newell, Mrs. E. J. Emery, Messrs. J. W. Calhoun, D. P. Barton and Dr. E. T. Edgerly, medical director. Pine Knoll Sanatorium, Davenport, sent Dr R. P. Carney, medical director, and Ethel Cross, R.N., superintendent. The State Sanatorium was ably represented by Drs. H. V. Scarborough, J. E. Dvorak and M. A. Cunningham. Sunny Crest Sanatorium at Dubuque sent Dr. J. C. Painter, medical director, and Charlotte Janes Garrison, R.N., superintendent.

The next meeting will be held in Cedar Rapids in February, following the annual conference of the Iowa Tuberculosis Association.

IN THE HOSPITAL

The doctor smiled, and said, "You may go home
Tomorrow;" and he looked surprised when I
Returned no answering smile. How should he know
The sudden shrinking of my tortured flesh
From all that "going home" implies to me?
I am so tired—so tired! And when I think
Of taking up the burdens that I dropped
When sickness bought for me a breathing space—
The grimy, odorous clothes, so hard to rub
To whiteness as I bend above the suds;
The food that must be bought, prepared and cooked;
The constant struggle to keep up the rent,
So that our poor, cheap sticks of furniture
May not be set out in the public street,
(Ah, God! that fear looms chief of all my fears!)—
Then is it strange that I should weakly cling
To this white cot, this atmosphere of rest,
Where I may sleep, afar from vendors' cries,
And noisy brawlings from the flat next door?
I almost hoped this pain would end all pain;
But no; the verdict's "Life!" I must "go home!"

—Florence Van Cleve in *Handbook of Organization and Method in Hospital Social Service.*

There's one of me that's humble, one that's proud;
There's one that broken hearted fir his sins,
And one who, unrepentant, sits and grins;
There's one who loves his neighbor as himself,
And one who cares for naught but fame and pelf;
From much corroding care I should be free
If once I should determine which is me."

—Selected.

THE MODERN HOSPITAL'S CONTEST FOR SMALL HOSPITAL PLANS ANNOUNCED

SUPERINTENDENTS of small hospitals and hospital workers and architects generally, manifested instant interest and enthusiam at the announcement of the architectural competition for small hospital plans to be conducted by THE MODERN HOSPITAL which was made by President George D. O'Hanlon at the opening session of the twenty-fourth annual conference.

This $1,000 competition has as its dual purpose the stimulation of small hospital construction which is efficient in arrangement, suitable for small communities and creditable in architecture and the provision to boards of trustees of small hospital floor plans that will combine simplicity of design and good taste with a compact arrangement of the various departments of the hospital now regarded as essential to the efficient and scientific care and treatment of the sick.

After looking over the general program of the competition, which was freely distributed at THE MODERN HOSPITAL booth, a number of architects expressed their approval of its method of conduct and purposes and signified their intention of entering the contest.

Even Superintendents Will Compete

Superintendents of several small hospitals then took up the cry announced that they too would consider entering the architectural competition. This they mean to do, they declared, by sketching their idea of what constitutes the ideal small hospital for their particular community and submitting these sketches to their local architects for drawing and elaboration.

The competition calls for a set of plans of a general hospital of from 30 to 40 beds. Registration for the contest must take place on or before November 15, 1922 and the final date for submitting designs is January 15, 1923.

The complete program of the competition follows:

1. PURPOSE OF COMPETITION: (a) To stimulate the building of small hospitals that are sufficiently arranged, suitable for smaller communities, as well as architecturally creditable; (b) To bring to the trustees of small hospitals floor plans that shall combine simplicity of design and good taste with a compact arrangement of the various departments of the hospital now regarded as essential to the efficient, scientific care and treatment of the sick.

2. MANAGEMENT OF COMPETITION: The competition will be conducted through THE MODERN HOSPITAL magazine with the cooperation of the leading architectural journals. The Modern Hospital Publishing Co., Inc., has appointed Richard E. Schmidt, of the firm of Richard E. Schmidt, Garden and Martin, 104 South Michigan Ave., Chicago, Ill., as the architectural adviser. He will determine and promulgate all details not herein set forth and necessary for the purpose of the competition, and all directions issued by him shall be supplemental to this program and as binding as if incorporated herein. He shall examine the designs to ascertain whether or not they comply with the terms of the competition and shall exclude any which do not.

3. JURY OF AWARD: The jury will be composed of two architects, two hospital superintendents and a graduate nurse who has had experience as the superintendent of a small general hospital; all to be selected by the chairman of the committee on competitions of the Illinois Chapter of the American Institute of Architects. The names of the jury will be announced before the closing date of the competition.

The jury will meet in Chicago or some other city to consider the designs and will place in their order of merit by secret ballot and majority vote, the five designs which appear to be the most meritorious. In reaching its decisions the jury will consider the merits of the designs, the merits of the plans from the standpoint of economy in construction and efficient operation, the integrity of the presentation and such other points as they may deem best, and award the three prizes and the two honorable mentions according to this program.

The award of the jury shall be final and binding on The Modern Hospital Publishing Co., Inc., which agrees to award the prizes and honorable mentions as follows:

4. AWARD OF PRIZES: To the author of the design placed first by the jury The Modern Hospital Publishing Co., Inc., agrees to pay the sum of $500 in cash as a prize, payable as follows: $300 immediately upon the award and the balance upon receipt and acceptance of tracings in ink on tracing cloth of the original competition plans, elevations and details and bearing the name of the author as architect. Such tracings to be suitable for blue printing. No tracing is required of the perspective drawing.

The drawings placed first and the tracings shall become the property of The Modern Hospital Publishing Co., Inc., but nothing in this argreement shall prevent the author from making individual use of his design, should he desire to do so.

To the author of the design placed second by the jury, The Modern Hospital Publishing Co., Inc., agrees to pay the sum of $300; and to the author of the design placed third by the jury, the sum of $200, said sums to be paid immediately upon the award.

To the authors of the designs placed fourth and fifth, The Modern Hospital Publishing Co., Inc., agrees to award honorable mention in the form of suitably inscribed certificates.

5. PUBLICATION OF DESIGNS: Thirty designs more or less will be selected for publication in book form. All designs awarded prizes or selected for publication shall become the property of The Modern Hospital Publishing Co., Inc., as their interest may appear and shall bear the author's name and address as architect, but nothing in this agreement shall prevent the author from making any individual use of his design that he may desire.

The Modern Hospital Publishing Co., Inc., shall be permitted to reproduce any drawings submitted in the competition in any manner it desires providing that every reproduction shall bear the author's name and address as architect, and may retain them for this purpose for three months after the award of the jury has been made.

6. DRAWINGS TO BE SUBMITTED: Each hospital submitted in this competition shall be illustrated on fairly heavy sheets of white paper. Mounting and very thin paper or cardboard are prohibited. It will be preferable to place the perspective and plat plan on one sheet; the floor plans on a second sheet; and the two elevations and section on a third sheet. All three sheets

shall be of the same size. All drawings submitted shall be packed flat, and adequately protected to prevent breaking, creasing or crushing.

A competitor may submit only one design; plans, elevations and sections shall be drawn to the scale of 8 feet to the inch. Each sheet shall have a border line half an inch from each edge. Plans, elevations and sections shall be in ink and shall have all walls blocked in solid with black ink.

The perspective shall be in pen and ink without wash or color, and may have accessories such as trees, shrubbery, automobiles and persons.

Dimensions of all rooms shall be noted in numerals and letters about ¼" high. Each room shall be numbered and its use indicated by a legend appearing at the side of the plan and numbered to correspond.

A graphic scale and the points of the compass must appear on the drawings. One of the drawings should show the principal approaches, such as the main entrance, the ambulance entrance, the service entrance, driveways, streets and alleys, as well as contour line, if any.

The illustrations required are the perspective drawn at a scale of 8 feet per inch; elevations of two sides not shown in the perspective, floor plans of all floors and basement, and wall section showing height of stories, including basement.

REQUIREMENTS OF THE HOSPITAL: The capacity shall not be less than 30 or more than 40 beds.

(a) ROOMS AND WARDS

1. Private and semi-private rooms (single and double rooms, some with private baths and water closets) ..... 16-20 beds
2. Women's ward .....4, 5 or 6 beds
3. Men's ward .....4, 5 or 6 beds
4. Maternity ward .....one or two 2 bed or one 4 bed
5. Children's ward .....one 4 bed
6. At least 2 one bed rooms accessible to the wards for recovery and segregation.

The number of private rooms may be more than sixteen but not more than twenty; the capacity of the women's and men's wards may be four, five or six beds, or, on one or more additional four-bed wards may be introduced.

There shall be at least 80 sq. ft.* of area per bed in the wards for adult patients, and not less than 60 sq. ft. in the children's ward.

(b) SERVICES

There shall be separate services for private and ward patients and at least one complement on each floor, designed for use of patients.

1. Charting space.
2. Medicine closet and sink.
3. Pantry, 130 to 160 sq. ft.
4. Utility room, not less than 120 sq. ft.
5. Linen closets not less than 50 sq. ft., or linen room not less than 100 sq. ft.
6. Janitor's closet.
7. Supply closet.
8. (Additional conveniences optional.)

(c) VERANDAS

There shall be at least three separate veranda spaces, —for ward patients, private patients and children.

(d) OPERATING DEPARTMENT

Operating room, not less than 15 ft. wide and 15 ft. long.

1. Sterilizing room, 180 sq. ft.
2. Doctor's scrub-up room, 65 sq. ft. (may be combined with doctors' dressing room.)
3. Doctors' dressing room with lockers and toilet, 100 sq. ft.
4. Nurses' dressing room with lockers and toilet, 100 sq. ft.
5. Nurses' workroom, 180 sq. ft.
6. Anesthesia room, 100 sq. ft.
7. Minor operating room planned to serve as an emergency or delivery room; suitable also for dental, eye, ear, nose and throat and for systoscopic work, not less than 14 ft. wide and 15 ft. long.
8. Accident receiving and surgical dressing room.
9. Birth room, not less than 14 ft. wide and 15 ft. long.
10. Nursery, 180 sq. ft.
11. X-ray room, 225 sq. ft.
    Dark room.
    Small dressing room.
    Plate storage room.
12. Clinical laboratory, 225 sq. ft.

(e) IN GENERAL

1. Drug room, 150 sq. ft.
2. Waiting room for out-patients.
3. Treatment room for out-patients.
4. Clinical record room (may be combined with office or visiting doctor's consultation room.)
5. Office.
6. Reception room.
7. Visiting doctors' consultation room, 150 sq. ft.
8. Locker and dressing room with bath for graduate nurses, 150 sq. ft.
9. Kitchen, including facilities for the preparation of special diets.
10. Cold storage room.
11. Storage for groceries.
12. Officers' dining room.
13. Nurses' dining room.
14. Helps' dining room.
15. Resident physician's bedroom and bath, 120 sq. ft.
16. Superintendent's bedroom and bath.
17. Two bedrooms for male help, with bath room.
18. Two bedrooms for female help, with bath room.
19. Laundry.
20. Clean linen room.
21. Boiler room, (but not lighting or power plant) and coal bin.
22. Storage rooms for miscellaneous supplies.
23. Lavatories and toilets, as required.

The buildings should be planned to admit of expansion and the drawings should indicate the direction of this expansion.

It is assumed that the nursing staff will be accommodated outside of the hospital.

For the care of contagious diseases the hospital contemplates building a small isolation cottage. Its inclusion on the plat is optional.

Inasmuch as it is the purpose of the competition to bring out new thought, competitors are free to introduce into the plan elements which they regard as desirable, which are not specifically included in the slated program.

Obviously, provisions should be made for such necessary parts as elevators, stairs, dumb waiters, soiled linen chute, boiler flue, etc., etc.

8. *ANONYMITY AND TRANSMISSION:* No name or mark or sign shall be placed on the drawings or on the package containing them by which the author may be identified. (If the sender's name and address be required

*All areas stipulated in this program are expressed in feet and are mandatory minima.

on the package, as in mail or express, a name of a representative may be substituted for that purpose). No competitor shall reveal either directly or indirectly the identity of his design or hold any communication regarding the competition with any member of the jury. With each set of drawings, which shall be packed flat and adequately protected to prevent breaking, creasing or crushing, there shall be enclosed a plain, opaque, sealed envelope, without any superscription or mark of any kind, containing the name and address of the competitor. These envelopes shall be opened by the architectural adviser after the selection has been made by the jury. The opening of the envelope containing the name of the author of the design placed first by the jury will automatically make this program a contract between the author and The Modern Hospital Publishing Co., Inc.

Competitive drawings shall be addressed to The Modern Hospital Publishing Co., Inc., 22 East Ontario Street, Chicago, Illinois, in plain lettering, and delivered at this address or to the postoffice or express company not later than January 15, 1923.

Packages thus addressed will be opened and each sheet and the envelope therein given a distinctive mark. The envelopes will remain unopened until the awards are made by the jury.

Drawings are at the author's risk until returned, although reasonable care will be taken in their handling and keeping. Drawings not receiving prizes or not selected for publication will be returned to their respective authors immediately after the judges have made their awards.

Contestants are expected to register their intention of entering the competition on or before November 15, 1922, with the architectural adviser.

9. *COMMUNICATIONS* (Mandatory): If any competitor desires information of any kind whatever in regard to the competition or the program he shall ask for this information by anonymous letter addressed to the architectural adviser, and in no other way, and a copy of this letter and the answer thereto will be sent simultaneously to each competitor, but no request made after December 15, 1922, will be answered.

MAKING THE HOSPITAL CAMPAIGN A SUCCESS

"Carl N. Garland made the following statement of methods used in the community campaign for $150,000 for the Billings (Montana) Deaconess Hospital, of which he is superintendent: 'The situation here was one of extreme pessimism, and a campaign of optimism necessarily preceded any attempt to secure money. Apart from an atmosphere of assurance, which was necessary on my own part, and which was manifested on all occasions, and in the face of all opposition, it was found exceedingly valuable to organize a Deaconess Hospital Auxiliary, composed of the leading executive officers and one or two others of the respected Protestant women's organizations. My communications were necessarily read before the lodges which was distinctive publicity in itself. Their response, which was immediate, secured me a group of the most prominent women in the city, who having once identified themselves with the movement, were committed to its success and began at once boosting. Public announcements from time to time indicated the needs and assurance of the hospital.

Members of Organizations Interviewed

'The next move was to interview individual members of all the organizations in the city, cultivate a friendly attitude and convert them into champions of the cause. Having secured their confidence, it was possible to count upon their action in their respective clubs and fraternities. Being assured of such a friendly nucleus in each organization, a communication was sent to their respective secretaries, with a comprehensive statement of the Billings Deaconess Hospital program and its needs. The promised returns from the standpoint of the special service it would render in the interest of the particular club were stressed. If the communication was to a church, its generous philanthropy was urged, if to a commercial club, its distinctive economic value to the city was pointed out as well. If it was to a rotary club, the appeal was to civic pride in securing such an institution. Resolutions of support and endorsements formed the basis of a good advertisement, which was published on the eve of the campaign, showing how everybody favored the project. In fact, the setting up practically compelled the sympathy and support of all, as no organization would care to be called antagonistic in the face of such universal public support.

Business Men Made Team Captains

'Team captains were secured who were, from the standpoint of the campaign, the most prominent men in the business life of our city, and preparations were made for a large group of canvassers. Arrangements were entered into with the press whereby they published the educational material some six weeks or more in advance of the campaign, and articles were sent to all the papers within a radius of one hundred and fifty miles. I secured the cooperation of the Masonic, Odd Fellow, and Pythian bodies, having them prepare a letter to the membership of the lodges throughout the territory from which we were seeking support. This letter was signed by the chief executive officers of the local lodge, sent to the secretary of the different outside lodges and signed by him and forwarded from the local postoffice.

'I then prepared a letter signed by the executive committee, which with a folder and the campaign literature was forwarded to the entire population.

'We were now ready for action, and in the face of a three year drouth, which quite paralyzed the prosperity of this section of the country, with finances in a most stringent condition, and in the face of a falling wheat market, against the opposition of practically the whole board of directors, who feared failure because of their lack of faith in the resources of the country, in three months, over $100,000 was subscribed.' "—RALPH WELLES KEELER, Director of Publicity for Hospitals and Homes of the Methodist Episcopal Church.

EVERY MAN HIS OWN PAYMASTER

There are many paymasters back of every pay check, and back of yours are our customers, our visitors, our prospects, all those to whom we write, all the people through whose hands our goods may pass and all who have occasion to judge our service down to the final recipient or consumer of our goods. The people from whom we buy—yes, even competitors into whose hands our goods may fall and be judged—all these are your paymasters.

Inasmuch as your work helps to determine the standards of quality and service for which we strive and as these standards reflect credit to all who take a part in the routine or conduct of this business and because of the fact that your success depends first of all upon the success of those with whom you are associated—You are in the last analysis Your Own Paymaster.

REPORTS SUBMITTED TO THE CONVENTION

REPORT OF THE BOARD OF TRUSTEES

SINCE the last report to the association, your trustees have held six regularly called and one unofficial or impromptu meetings. The impromptu meeting was made possible by the presence of a majority of the members of the board in Chicago, March 9-10, in attendance at the sessions of the American Conference on Hospital Service. At each of the meetings the president presided.

A statement of the financial transactions classified into a formal report is sent to each trustee every month. These reports are given consideration at each meeting and keep the trustees informed at all times as to the financial conditions of the association. The changes in the membership roll of all classes are also reported to the trustees each month.

Only a few of the specific acts of the board can be reported here. The decisions to be mentioned in this report are those which appear to have direct bearing on the conduct, the discussions and the possible acts of this conference. The plans and facilities for the conference itself, however, speak for themselves.

The following resolution recommending the enlargement of the nominating committee was passed at the meeting in West Baden, September 16, 1921:

Voted: That the trustees recommend to the constitution and rules committee that they consider the question of enlarging the nominating committee from three to five members that all the natural geographical sections of the hospital field may be represented thereon.

At the meeting held in New York, January 12, resolutions were adopted recommending to the committee on constitution and rules the extension of active personal membership to include "the executive officers of any state—or nationwide organization having as its primary purpose the development of hospitals and hospital service." It was also recommended to include the retiring president among the ex officio members of the board of trustees.

Between busy sessions, Dr. A. R. Warner, executive secretary, and Dr. E. R. Crew of Miami Valley Hospital, Dayton, found time for a chair ride on the Boardwalk.

Uniform Constitutions for Sections

The need for uniformity in the constitutional provisions for personal membership in the American Hospital Association and in all of the Geographical Sections was discussed by the trustees at this same meeting and by appropriate resolution they expressed their opinion that harmonious and effective organization required their uniformity. The president was authorized and directed to call a meeting of the officers of the Geographical Sections to determine upon a wording of these provisions acceptable to all.

The trustee section which holds its first session with this Conference was authorized at the West Baden meeting September 16.

At the first meeting of the present board, there was discussion of the need of the association for an immediate increase in the available funds and the raising of a guarantee fund. "It was the consensus of opinion of the trustees that at the present time it was better for the Association to make further attempts to provide itself with the necessary funds through increase in memberships before asking contributions to a guaranty fund. It was, therefore, voted that the association should at this time make direct appeal to all state, city and other hospital associations and to all institutional and personal members to assist in the securing of additional memberships to the end that funds now urgently needed for the development of the association and its service to the field be in this way provided."

The report of the committee supported by the Rockefeller Foundation to work out plans for the training of hospital superintendents was considered at the meeting in Chicago, June 16. The two following resolutions were unanimously adopted:

RESOLVED: That the trustees of the American Hospital Association do hereby express unqualified approval of the report of the special committee appointed by the Rockefeller Foundation for the study of the training of the hospital superintendent, both as to the principles set forth and the statements made and also as to the suggestions for future procedure and action; and be it further

RESOLVED: That the trustees do hereby urge upon the Rockefeller Foundation and other institutions which can make practical contributions thereto consideration of the suggestions in this report as to future action, that the actual training of hospital superintendents in the required numbers and along the lines suggested by the report may be accomplished at the earliest possible date."

This report will be discussed in the administration section.

The plan for the exposition committees serving at this conference was developed and authorized at the meeting held in the Bellevue Hospital, January 12.

At this meeting, the regulations were drawn requiring that the approval of all reports and bulletins by a committee of the trustees be secured before publication and distribution.

A committee of the trustees was appointed to work out a plan for voting better suited to the present size and constitution of the association than the past routine. This committee reported at the meeting held in Chicago, June 16. The details of this report, which was approved by the trustees, have been published in the Bulletin, in the magazines, and otherwise announced. The registration for this conference in proceeding on this basis. Every person entitled to vote should become familiar with it.

It is the opinion of the trustees that the past year has been a prosperous one for the association and that distinct progress was made.

REPORT OF THE EXECUTIVE SECRETARY

The progress of your association in the past year markedly exceeded that of the previous year. The reports of the trustees, of the membership committee, the treasurer, and all other reports will attest this. We are meeting for the first time in a building designed and used for the meetings of national groups; we have outgrown even the largest hotels. This conference, this attendance, this program, the special reports which have been prepared with so much care and the exposition in the adjoining hall speak for themselves.

There are, however, a few facts about the past year which must be told—facts which account for the accomplishment of the foundation work, for the acceleration of progress and for the energy that has made the wheels move the faster.

For the last four years to the personal knowledge of the writer, your trustees have exercised a progressively increasing degree of control and supervision over the activities of the association. Matters that were a short time ago routine decisions in the office of the secretary are now determined by vote of the trustees after mature consideration of the question. This is the real basis of the recent growth in the activities of the association and this is the guarantee of further development.

The number of those willing, even anxious to work hard with the association on committees or alone for the common welfare, for service to the field and for the advancement of the association seemed multiplied many fold. Any call was responded to as never before.

To those who have served on official committees the association will express its thanks, but to those unnamed, numbering many times more, who have responded just as cheerfully to the call for work and who have made equally good at the tasks set before them, the writer desires to express for the officers of the association our thanks and high appreciation. We wish also to transmit to them the sincere gratitude of the institution and persons helped. The superintendent who compiles facts and figures for others and considers problems existing in another institution is certainly one who is effectively doing the real work of the association and rendering service to the field.

Type of Correspondence Changed

The tenor and type of the correspondence changed in several ways. The letters requesting information or presenting problems for consideration were written, not to a person but as to an institution. They simply assumed that such was the routine procedure to learn of compiled facts or to get a consensus of opinion of the best informed. To the answers many, even hundreds of persons and institutions both within and without the association, contributed. There was also the general assumption that the association existed for the development of the field and belonged to the field.

There has been more correspondence with the trustees of hospitals and more letters from outside sources seeking general information concerning the field. Many letters also indicated that the association had become more widely known.

The stronger position of the association is reflected in the exposition. The increase in size this year is through the addition of new lines and larger, stronger firms more nearly representing basic production. We could not have secured an exposition like this last year even by the expenditure of great effort. It came of itself this year.

In our accomplishment we are happy, but compared with the opportunities and possibilities clearly open to an association of the American and Canadian hospitals and hospital people they seem so meagre—even for a single year work.

Your executive secretary evaluates all facts, figures and evidences of the activity of the association in terms of their contribution toward the development of a stronger active organization of the hospitals and hospital people to build their betterment and that they may have more to give in public service,—the kind of an organization that many industries have developed to advance their interests in every way and to improve their production, the kind that impels every member to take pride in his membership and use it, the kind that returns to each member in knowledge gained and in stimulated action a value many times any membership fee. The common responsibilities of hospitals through their trustees and managers under any name demands such an active and general organization, both for the protection of the institutions and in the interests of the public. These responsibilities are increasing with each advancement in the medical science and every development or standardization of institutional activity.

Liabilities of Hospitals Increase

It can not be forgotten that every patient must necessarily stake his all on that one particular hospital. No other aid can reach him. It is this fact that makes the management of every hospital so serious a trust. Who is to blame when a hospital loses lives from a high percentage of infections? The various alibis advanced by hospital trustees and managers when in trouble become of no practical moment in the face of the growing unanimity in supreme court decisions. These are placing a steadily increasing responsibility upon the institutions themselves, demanding from their managers a proper protection of the public as their function and duty.

The big problems and responsibility of any board of trustees and any superintendent are to know what is the best service, what are the best policies and practices, what are the best end results that can be attained and how to get them in their hospital. Can they ever know or even be reasonably assured from their own experience and performance alone that they have the best or that their results have required only a justifiable expenditure of money and effort? To know this constant contact with the rest of the field it is essential that there may be the necessary comparison, and comparisons reduced to equal terms. There is need at reasonable intervals for the stimulus from personal contact and contentions with others facing the same problems; there is need for the actual seeing, handling and study of the improved productions in equipment and materials used; there is need for thinking that daily routine will never provoke or permit; there is need for an organized way to ask a question that the quesions of all may be answered without imposing burdens; there is need for concerted action and the establishment of recognized standards of work.

The American Hospital Association was organized, developed and exists to act as the medium and means through which all this may be accomplished and to aid all hospitals and their trustees or managers under any name to fulfill the trusts and duties they have assumed.

Dr. Henry Ladd Stickney of the U. S. Public Health Service Hospital No. 53, Dwight, Ill., has accepted the position of superintendent of the Presbyterian Hospital of New Orleans.

REPORT OF MEMBERSHIP COMMITTEE

Your membership committee begs to submit the following report of its work during the past year.

Your committee has received, considered and either approved or disapproved of all applications for institutional membership, and all applications for personal membership, except those submitted by the Geographical Sections. The membership committees of the several Geographical Sections pass upon all applications for personal memberships in their respective states and routinely report accepted members to the office of the executive secretary of this association.

Our report includes many new personal members, the figures submitted combine those approved by your committee, and those recommended by the Geographical Sections.

INSTITUTIONAL MEMBERSHIP

ACTIVE

Institutional members on roll at last conference	358	
New members accepted since last conference	110	
	468	
Resignations	2	
Number on roll Sept. 1, 1922		466
Net increase for the year 108, or 30%. To be compared with a net increase last year of 48, or 15%.		
ASSOCIATE		
Number on roll Sept. 1, 1922		7
(This form of membership did not exist last year.)		
Total number of institutional members of both classes, Sept. 1, 1922		473

PERSONAL MEMBERSHIP

HONORARY

Total number of honorary members	10
(No change this year or last year.)	

LIFE

Active:			
Total number of active life members		26	
(No change in the past year.)			
Associate:			
Members on roll at last conference	5		
New members accepted since last conference	1		
Number on roll Sept. 1, 1922	—	6	
Total number of life members of both classes, Sept. 1, 1922		—	32
Net increase for the year, 1, or 3%. To be compared with a net increase last year of 15, or 93%.			

ACTIVE

Members on roll at last conference		1,082	
New members accepted since last conference		260	
Associate members transferred to active membership		2	
		1,344	
Resignations		88	
Number on roll Sept. 1, 1922			1,256
Net increase for the year, 174, or 15%. To be compared with a net increase last year of 207, or 23%.			

ASSOCIATE

Members on roll at last conference		204	
New members accepted since last conference		65	
		269	
Resignations	22		
Members transferred to active membership	2		
	—	24	
Number on roll Sept. 1, 1922			245
Net increase for the year, 31, or 15%. To be compared with a net increase last year of 17, or 9%.			
Total number of personal members of all classes on roll, Sept. 1, 1922			1,543
Net increase for the year, 216. To be compared with a net increase for last year of 238.			

Your committee wishes to call the attention of the association to the constitutional provision creating associate institutional membership. This class of membership was added at the meeting a year ago, so that organizations connected with or interested in hospitals might have direct information from this association concerning hospital work and also receive the literature sent out by this association. The members accepted under this constitutional provision include:

One national department having jurisdiction over the hospitals of the nation—namely, Department of Health, New Zealand.

One state department having jurisdiction over the hospitals of the state—namely, The Pennsylvania Department of Public Welfare.

One university medical college—namely, Cornell.

One new type of organization in the hospital field—namely, The Joint Administrative Board of Columbia University and Presbyterian Hospital.

One state organization of hospital department work—namely, The Illinois Society of Occupational Therapists.

One national committee—namely, The National Hospital Day Committee.

And one, only one organization of a hospital—namely, The Woman's Auxiliary Board of the Presbyterian Hospital of Chicago.

We can safely say that the desire for routine information as to the activities of this association prompted each of these applications.

It is clearly to the best interests of every hospital and every hospital executive that all organizations connected with hospitals affiliate themselves with this association in this way, thus receiving the literature sent out by the association and obtaining the trend of thought and action as expressed in and through the association.

We cannot close this report without asking the following question: Why are the organizations so few and in such a minority when they can be so readily reached by the hospital executives represented in the above membership?

Respectfully submitted,
WALTER H. CONLEY, Chairman.
C. J. CUMMINGS.
CHARLOTTE J. GARRISON.

SOME VARIATIONS IN THE PROGRAM

Several of the speakers scheduled for the convention program were compelled to cancel their speaking engagments at the eleventh hour. Among these was Dr. Royal S. Copeland, commissioner of health of the city of New York, whose name was presented during that week as a candidate for governor of New York. A. O. Fonkalsrud of Minot, N. D., who was down for an address on "Some Essentials in Hospital Organization," was unable to be present on account of an intensive financial campaign in progress at his hospital.

Governor Edward I. Edwards of New Jersey sent a substitute to welcome the delegates to the state and Atlantic City. Dr. Haven Emerson, professor of hygiene and public health at Columbia University, also was unable to be present, but sent his paper for the dispensary section on "The Educational Value of the Out-Patient Department in Relation to the Patient and the Community."

The American Occupational Therapy Association members deeply regretted that their president, Dr. Herbert J. Hall, was not sufficiently recovered from his illness to attend its sessions.

An unscheduled visitor and speaker was Commissioner Bird T. Coler of the department of public welfare, New York. Edwin R. Embree, secretary of the Rockefeller Foundation, who has recently returned from the Orient, was a convention guest and talked briefly on hospital conditions in China.

"Be a judge of the work of others of whom you are in charge, not a detective; your mere detective 'is wonderful at suspicion and discovery,' but is often at fault, foolishly imagining that every one is bad."—Florence Nightingale.

FLOORING COMMITTEE SUBMITS NOTABLE REPORT*

AT THE beginning of this survey a questionnaire was developed in collaboration with architects, hospital superintendents and manufacturers of flooring material that attempted to visualize the needs of hospitals and to secure a composite evaluation of the pertinent requirements of various types of hospital service.

The results of this questionnaire were far from satisfactory. Out of the number sent, approximately 1,700, ten complete replies were received, with a total response of not to exceed twenty-five. Most of the replies expressed an absolute ignorance of the individual as to the basic requirements of the ideal floor or floors and how to obtain them. However, the expressed evidence of interest in the result of the study but emphasized the need for the analysis.

By reason of the failure of the questionnaire to produce a volume of replies that would warrant it being considered the composite opinion of the hospital field, it was felt after consultation that some means of formulating an opinion and basing recommendations should be developed. To that end the committee developed a series of laboratory tests, the results of which are included in this report and in the exhibits accompanying it. The results of some of these tests cannot be graphically illustrated, and an inspection of the exhibits is prerequisite to a thorough understanding of the recommendations.

It first of all must be definitely understood that the committee does not presume to suggest that the most ideal laboratory tests are all-conclusive. After all, the true test of any commodity is the actual service that it renders under normal conditions of service. These laboratory tests are the result of considerable thought and attempt to determine in an approximate way only the various relative properties of all of the floor samples submitted. The detail of the tests are as follows:

Test No. 1—ABRASION.

The purpose was to ascertain the relative wearing quality of samples submitted. Comment may be made that the test is more harsh than the usual floor will receive under normal wearing conditions. However, in view of the fact that all samples were submitted to identically the same test, comparisons are fair.

The procedure of the test was that the sample was mounted on a firm foundation and submitted to an emery wheel without pressure other than the pressure of the wheel, for a period of five minutes.

Test No. 2—RESISTANCE TO PRESSURE.

None of the so-called hard type of floors were submitted to this test. The purpose was to determine the degree of pitting under average hospital service.

The procedure was that samples were placed on a firm foundation and had applied to them (under fifty pounds of pressure), a metal surface similar to that used for protecting table and chair legs, for a period of thirty days.

Test No. 3—FIRE RESISTANCE.

The purpose was to establish how the material would stand up under the very common practice of throwing lighted cigarettes on the floor. Completely lighted cigarettes were placed on the sample and permitted to burn out entirely.

Test No. 4—ABSORBENCY.

The purpose was to determine the condition of floors after usual cleaning procedures for a period of time. There is a certain group of flooring material that if examined at the base after a year or so of service will evidence a degree of filthiness due to absorbency of mop water that would absolutely preclude their use in a hospital.

The procedure was to weigh the sample carefully on an accurate scale, immerse completely in water for twenty-four hours, remove from water and immediately weigh, and re-weigh at five day periods for fifteen days, indicating the percentage above normal at each weighing period.

The following table in the next column indicates the results:

Test No. 5—ACID AND ALKALI RESISTANCE.

This test is self-explanatory and the purpose self-evident.

Samples were submitted to application of concentrated nitric, sulphuric, hydrochloric, oxalic and acetic acids. No attempt was made to remove solutions applied.

Test No. 6—STAINING.

The purpose and desirability of this test are equally as evident as test No. 5. Floors were submitted to applications of hot grease and blood for staining and applications of methylene blue, carbofuxine and iodine to show capillarity and absorbency.

Superficially it would appear that a discussion of floors should take into consideration only the commodity of which the wearing surface is made, but as a matter of fact this commodity is but one angle in the selection of the ideal hospital floor.

		Increase in Weight 24 hrs.	Five Days	Ten Days	Fifteen Days
7	Adamantile	6%	†N		
10	Alundum art tile	9%	4½%	4½%	†N
17	Linoleum—household (Armstrong)	*NI			
22	Asbestone	10%	5%	5%	†N
39	Terrazzo	*NI			
41	Carborundum floor tile	5%	1%	1%	†N
50	Duratex	5%	†N		
53	Copperstone	6%	†N		
56	Crescent cork tile flooring	33⅓%	†N		
57	Linoleum—inlaid (Armstrong)	*NI			
58	Cork tiling	*NI			
63	Detroit brand	33⅓%	†N		
65	Domestic quarries tile	3%	1½%	1½%	†N
66	Double diamond interlocking rubber tiling	15%	†N		
68	Duraflex	*NI			
72	Everlastic tile	20%	†N		
73	Feralum anti-slip	14%	†N		
77	Flexotile	11%	8%	6%	†N
78	Flexstone	*NI			
79	Flint tile	3%	3%	†N	
86	Gold seal battleship linoleum	*NI			
93	Hexagonal tile (vitreous)	3%	†N		
96	Imperial sanitary fireproof	17%	9%	†N	
97	Inlaid sheet tiling	19%	12%	†N	
100	Kellastone	25%	11%	7%	†N
101	Keystone	*NI			
102	Kompolite	24%	5%	†N	
105	Korkstone	12%	†N		
109	Limestone—Indiana	*NI			
111	Linoleum—battleship (Armstrong)	20%	†N		
116	Appalachian marble	*NI			
117	Georgia marble	*NI			
118	Mt. Nebo marble	*NI			
119	Vermont marble	*NI			
124	Masterbuilders concrete with hardener	6%	†N		
122	Marbleloid	79%	†N		
128	Mineral flooring	200%	150%	†N	
131	Nairn's linoleum (battleship)	*NI			
133	Nonpareil cork tiling	66%	†N		
140	Protectile	*NI			
155	Solry	*NI			
157	Ceramic tile	100%	†N		
158	Naturized rubber	*NI			
160	T. M. B.	*NI			
161	Compoloid	*NI			
164	Touraine quarries tile	10%	7%	7%	5%
168	Unico elastic tile	*NI			
170	Usco	*NI			
171	Velvetile	*NI			
172	Non-slip floor tile (carborundum)	33⅓%	16⅔%	†N	
174	Welsh quarries tile	3%	3%	3%	†N
178	Zenitherm art cork	20%	14%	†N	
179	Rub-R-Art	33%	33%	†N	
182	Alundum safety aggregate tile	3%	†N		
183	Linotile	NI			
184	Cement—no hardener	10%	†N		

*No increase. †Normal.

The base upon which a floor is to be laid is the predetermining factor in the selection of that floor. In newer types of construction those entrusted with construction are met with probably only one kind of base, either a finished or unfinished concrete slab. There is, however, the problem of old installations requiring the laying of floors over an old wooden base (or one of a comparable nature); any group entrusted with such an installation should know beyond a measure of doubt that the commodity it is selecting will stand up under prevailing conditions.

Of equal importance is a discussion of the type of cove, and the type of wainscoting that are to be used. Some floors permit of the installation of both cove and wainscoting as an integral part of the floor itself and of the same material. This is highly desirable under some conditions.

*An abstract of the report of the Committee on Floors presented at the twenty-fourth annual conference of the American Hospital Association by Frank E. Chapman, chairman.

The importance of a consideration of this problem is herein emphasized.

There is of course at all times the problem of first cost that injects itself into a consideration of the hospital floors. This is always a very vital factor in the determination of the flooring to be installed. It would be presumptuous for the committee to attempt to set up a schedule of floor costs, by reason of the inaccuracy of such a table. The question is merely put at this point to draw attention to several vital factors that enter into the after-cost of any installation.

The floor that requires waxing, polishing, surfacing or surface treating may produce a maintenance cost per yard per year that will more than offset the difference between it and another of a higher initial cost. Therefore it is recommended that consideration be given to the procedures of maintenance and the cost thereof, in determining whether or not the initial cost is high.

Another phase in a determination of flooring installation is the relative expectancy of usage. It is needless to say that a floor which will last fifteen years at an initial cost of $1.00 a foot is less expensive than a floor that will last five years at an initial cost of fifty cents a foot.

Were we able to develop a monolithic type of floor that would remain as originally installed, without joints and crevices, there is no question but that that floor would be the ideal floor from the standpoint of sanitation, maintenance and appearance, and if with that type of floor we could secure comfort and noiselessness, we would have obtained the ideal hospital floor. But, as a matter of fact, with expansion and contraction incident to all types of construction, monolithic floors never retain their original form, and as a consequence we have expansion and contraction cracks that must be resurfaced. The problems of durability, maintenance, continuous availability and ease of repair immediately present themselves.

On the other hand, in the installation of other than monolithic types, a determination of the type of the floor must take into consideration the character of the joining material, in order to insure the same degree of sanitation, acid and alkali resistance and appearance in the joining material as in the flooring material proper.

A further consideration must determine whether or not the floor is an integral or surface flooring, *i. e.*, whether after a certain period of usage the surface will have been worn down and present a material that is not at all comparable in terms of efficiency to the original installation. There are certain types of flooring that offer this problem.

It is the belief of your committee that any recommendations of hospital floors must be predicated upon the ratio of evaluations of the pertinent requirements by individual boards of trustees. To illustrate specifically, certain types of floors have a relatively high rating in terms of ease of repair and maintenance and a relatively low rating in appearance, noiselessness and comfort. Certain other types have a high rating in appearance but a relatively low rating in ease of repair, acid and alkali resistance, etc. It is

		Abrasion	Pressure	Fire	Absorbency	Acid and Alkali	Staining
7	Adamantile	C	NT	A	B	B	E
10	Alundum art tile	A	NT	A	C	D	C
17	Linoleum—household (Armstrong)	D	C	E	A	E	C
22	Asbestone	B	NT	B	C	E	D
39	Terrazzo	A	NT	A	A	C	E
41	Carborundum floor tile	A	NT	A	B	C	B
50	Duratex	B	NT	B	B	D	B
53	Copperstone	E	NT	B	B	C	C
56	Crescent cork tile flooring	C	B	E	D	E	E
57	Linoleum—inlaid (Armstrong)	D	B	D	A	E	C
58	Cork tiling	C	C	E	A	D	D
63	Detroit brand	E	C	C	C	E	C
65	Domestic quarries tile	A	NT	A	B	A	A
66	Double diamond interlocking rubber tiling	B	B	B	C	C	B
68	Duraflex	E	NT	B	A	B	A
72	Everlastic tile	D	D	D	C	D	C
73	Feralun anti-slip	B	NT	A	B	A	D
77	Flexotile	B	NT	B	C	E	B
78	Flexstone	B	NT	B	A	D	B
79	Flint tile	B	NT	A	B	A	A
86	Gold Seal battleship linoleum	D	C	D	A	D	C
93	Hexagonal tile (vitreous)	B	NT	A	B	A	B
96	Imperial sanitary fireproof	C	NT	No	C	D	B
97	Inlaid sheet tiling	C	B	E	C	D	C
100	Kellastone	B	NT	A	D	B	B
101	Keystone	E	C	E	A	B	A
102	Kompolite	B	NT	A	C	E	B
105	Korkstone	B	NT	B	B	E	C
109	Limestone—Indiana	B	NT	A	A	C	E
111	Linoleum—battleship (Armstrong)	C	C	E	B	D	C
116	Appalachian marble	A	NT	A	A	E	E
117	Georgia marble	A	NT	A	A	A	E
118	Mt. Nebo marble	B	NT	A	A	C	B
119	Vermont marble	A	NT	A	A	C	E
122	Marbleoid	B	NT	B	D	D	D
124	Masterbuilders concrete with hardener	A-B	NT	A	B	C	D
128	Mineral flooring	B	NT	B	E	D	D
131	Nairn's battleship linoleum	B	C	E	A	D	C
133	Non-Pareil cork tiling	B	C	E	C	E	E
140	Protectile	C	NT	A	A	C	E
155	Solry	A	NT	A	A	B	E
157	Ceramic tile	B	NT	B	C	A	D
158	Naturized rubber	A	A	A	A	B	A
160	T. M. B.	E	NT	E	A	C	B
161	Compoloid	B	NT	B	A	E	B
164	Touraine quarries tile	C	NT	A	E	A	A
168	Unico elastic tile	E	C	E	A	D	C
170	Usco	C	B	B	A	B	C
171	Velvetile	NO	NT	C	A	D	NO
172	Non-Slip floor tile (carborundum)	C	NT	A	C	A	B
174	Welsh quarries tile	B	NT	A	B	A	A
178	Zenitherm art cork	C	A	C	C	D	D
179	Rub-R-Art	C	B	D	C	C	B
182	Alundum safety aggregate tile	A	NT	A	B	A	C
183	Linotile	E	C	E	A	C	C
184	Cement—no hardener	C	NT	A	B	C	E

Mr. Chapman's laboratory evaluation of flooring samples met with constant inspection.

therefore incumbent upon the individual group interested in an installation to determine which requisites are paramount in its particular case, and then to select the floor that has an index of requirements highest for its particular need.

There is a growing tendency in hospital installations today, by reason of the apparent economy of maintenance, to make installations of certain of the hard types of flooring. With our modern methods of construction, the problem of noise in a hospital is becoming increasingly obnoxious, and it is incumbent upon those entrusted with the construction of hospital buildings to offset in every way possible the disadvantage incident to concrete and steel construction in this respect, by the installation of flooring materials that will be efficient insofar as sanitation, durability, maintenance, fire resistance, ease of repair, continuous avilability, and acid and alkali resistance are concerned, and at the same time to use the material that will reduce either by absorption or by resilience the noise incident to hospital traffic. Therefore, it is believed that insofar as is possible those parts of the hospital allocated to patient occupancy and corridors should be treated with the so-called soft-type of floors. It is the belief of the chairman of this committee that this same treatment can be given in various other parts of the hospital, such as utility rooms, diet kitchens and operating rooms, but it would be presumptuous to make so radical a recommendation even though such installations have been made and are proving preeminently successful.

There is a definite objection to the soft-type of flooring in that it has not the durability of some of the other types. This objection was well founded up until the last few years. There has been, however, a development in this type of flooring that apparently has retained all of the advantages of the former group of soft floors, at the same time has overcome the objection of pitting, and seems to offer a resistance to abrasion which compares very favorably with the hard types of flooring.

Based upon laboratory tests, the committee in the table on the preceding page submits a list of all floor samples submitted with a rating on their relative efficiency under the different tests.

KEY FOR TABLE PAGE 12.

A Excellent	90-99	D Poor	60-69
B Good	80-89	E Very Poor	Below 50
C Fair	70-79	NT No Test.	

NOTE—While most of the wood flooring associations submitted samples, no gradings are made for the reason that no sample of wood floor can in any measure approximate actual service conditions. There are conditions under which wood floors may be used in hospitals but they are special ones and do not fall within the scope of this report.

There is also submitted for consideration and proper evaluation, a recommendation as to the best type of floor for various services.

TABLE OF RECOMMENDATIONS

		Soft Type	Hard Type
1	**Private Rooms**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
2	**Wards**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
3	**Service Rooms (see note)**		
	Utility, service kitchens, toilets, baths.		
	First choice	Reinforced rubber....	Flint tile (various colors)
	Second choice ..	Battleship linoleum...	Slate
	Third choice ...	Soft mastic.....	Concrete with integral hardener and coloring
4	**Corridors**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
5	**Service Corridors**		
	First choice	No recommendation..	Asphalt mastic
	Second choice ..	.....	Concrete with integral hardener and coloring
	Third choice ...	.....	.....
6	**Laboratories**		
	First choice	Reinforced rubber....	Quarry tile
	Second choice ..	Battleship linoleum...	Terrazzo in blocks
	Third choice ...	Soft mastic.....	Concrete
7	**Operating Rooms**		
	First choice	Reinforced rubber....	Flint tile
	Second choice ..	Battleship linoleum...	Terrazzo in blocks
	Third choice ...	Soft mastic.....	Slate
8	**Out-Patient Treatment Rooms**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
9	**Out-Patient Corridors**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
10	**Kitchens**		
	First choice	No recommendation..	Quarry tile
	Second choice ..	.....	Terrazzo in blocks
	Third choice ...	.....	Concrete with integral hardener and coloring
11	**Offices**		
	First choice	Reinforced rubber....	Terrazzo in blocks
	Second choice ..	Battleship linoleum...	Concrete with integral hardener and coloring
	Third choice ...	Soft mastic.....	.....
12	**Laundry and Comparable Services**		
	First choice	No recommendation..	Concrete with hardener and coloring

NOTE—On baths and toilets ceramic tile can be used to very good advantage, in fact is preferable to flint tile.

Conclusion

In conclusion, the committee holds for itself no thought of omnipotence. The subject of the ideal flooring is too vast and too important to be definitely decided by any one group. The report is the result of more or less continuous study over a period of two years. It has entailed rather arduous labor that has been cheerfully expended, not only because of the momentousness of the question but because it has visualized such a great ignorance of the problem under discussion and the necessity for more and more study of the question.

ADEQUATE TRAINING FOR HOSPITAL SOCIAL WORK*

DESPITE the fact that hospital social work as an organized part of medical institutions in America is over fifteen years old, there is as yet no unified authoritative opinion as to its function, policy and educational standards. Training for a field of work cannot be satisfactorily developed without a clearly defined conception of the field. A statement of principles for the education of hospital social workers should consequently begin with a definition of the work for which we are to educate.

Briefly, the function of the hospital social worker is to deal with the patient's personality and environment in such a way as to contribute to the physician's effort to cure and prevent disease. While the worker's efforts have thus a medical purpose or application, the activities themselves are social work—the investigation and adjustment of personality and environment. The training of the hospital social worker, therefore, must include medical knowledge sufficient to make clear the application and relationships of social facts to health; but the nature of the skill sought and of the technique to be developed is essentially the skill and technique of social work.

Requirements of the Field

In hospital social work, as in public health nursing, the worker is thrown into contact with patients and families under conditions which call for tact, resourcefulness, and ability to deal not infrequently with delicate personal situations, without the possibility of immediate recourse to some superior or larger experience. A degree of maturity is, therefore, essential. This can not be expressed in years, but, in general, the committee is of the opinion that students should not be accepted under the age of twenty-one and that in judging the qualifications of a student or a prospective worker for acceptance in a school course or for employment, maturity as indicated by personality, irrespective of years, should be an important consideration.

Preliminary Education

It is the opinion of the committee that the completion of four years of college training best expresses the general preliminary education which should be required of students entering a professional course of training for hospital social work. The committee does not consider that merely holding a college degree is essential, but believes that four years of work in a good college provides the best general index of intellectual maturity and mental discipline. It is recognized that there are many persons who would be highly acceptable as students who have not had the advantage of four years in college. Training in an acceptable school of nursing, following not less than two years of college work; training and experience in general social work with similar academic background, are two illustrations of preliminary educational qualifications which might well be considered acceptable. It is desirable that the college work should include biology, physiology and hygiene, psychology, and some course in social science, such as economics, sociology, or government. Broad general culture, mental alertness and flexibility, and a command of English are of more fundamental importance than familiarity with any special subject matter.

Length of Course

The course of training should cover a period of two years for students not entering with advance credit.

Essential Subject-Matter

Consideration was given to the plan of preparing several different courses of combined study and practice, each adapted to students of different preliminary education and training. After careful deliberation, the committee has thought it best to draw up a single course containing all the various elements which it believes necessary parts of adequate training for hospital social work; to specify the relationships and relative time limits of these elements, and to recommend that credit allowance be arranged for individual students whenever their previous education or training enables them to present equivalents for one or another portion experience in general social work with similar academic background, are of the course. The committee believes that only by this method can there be maintained a sufficiently high standard of training, and the equally indispensable condition of flexible adaptation of the course to students of varied preparation, such as are necessarily drawn into a new vocation.

The course should include a combination of practice and classroom work. The student must acquire three things: (1) understanding of principles; (2) adequate information concerning essential professional facts, medical or social; (3) ability in technique of work. Hospital social work can not be taught by lectures, conferences, reading and classroom exercises alone, any more than can medicine or nursing. The committee believes that at least half of the entire time given to training should be devoted to practice under supervision.

The principles and method of practice should be as follows:

(1) The social service department of a hospital is the field in which the student should spend most of his time.

(2) There should also be some practice in a family case work agency in order that the work of a non-medical agency be understood.

(3) Practice in hospital social work should be carried on chiefly in a single institution in order to preserve continuity.

(4) There should be some periods of observation in other medical and public health organizations.

(5) A long, uninterrupted period of practice is highly desirable.

(6) Practice and classroom work should be closely correlated.

(7) Practice should be supervised by the agency in which it is done. The plan of practice should be subject to the educational direction of the organization giving the course.

The subject matter of the classroom work should include the following elements:

The functioning of the human body, with such information regarding structure, heredity, and development as is necessary for the proper understanding of function; essential physiological processes; personal hygiene.

Selected problems of disease: studied, not from the standpoint of their pathology, but with special reference to the nature of the disability occasioned, the degree of communicability, if any, and the duration and character of treatment in its bearings upon occupation, family life and income, and the usual available medical resources.

*An abstract of the report of the Committee on the Training of Hospital Social Workers presented at the twenty-fourth annual convention of the American Hospital Association. The committee is as follows: Michael M. Davis, Jr., chairman, Dr. Louis B. Baldwin, Dr. Frank Billings, Miss Ida M. Cannon, Miss S. Lillian Clayton, J. E. Cutter, Miss Annie W. Goodrich, Miss Mary C. Jarrett, Dr. George O'Hanlon, John A. Lapp, Porter R. Lee, Roger I. Lee, Miss Kate McMahon, Dr. Lewis A. Sexton, Dr. Winfred H. Smith, Dr. Frankwood E. Williams, Dr. A. R. Warner, and Miss M. Antoinette Cannon, executive secretary.

Public health administration: The main functions and characteristic organizations of local, state, and federal health agencies, private agencies, and the chief present public health problems.

Medical institutions and organization: History and traditions of the medical and nursing professions, present day organization and problems of hospitals, clinics and private practice.

Human behavior: The functioning of mind and body, their interrelations in health and disease; psychology taught from the behavioristic point of view, with some special reference to the problems of psychiatry and of mental defect.

Community organization: The economic and social organization of society in nation, state, city and rural areas. Typical community problems, community agencies and community resources.

Industry: Characteristics and organization of modern industry and commerce, with special reference to the effects of occupation upon health.

Government: Organization of national, state and local governments, with chief reference to the working of governmental departments and agencies dealing with health, poverty, education, and with the institutional care of the dependent and afflicted.

Human adjustments: Another name for a course in social case work, dealing with the principles and methods of work with individuals and families in the endeavor to make those adjustments of personality and environment called for by various conditions and problems.

Statistics and research: Principles and methods of utilizing figures, of viewing facts critically, and of dealing with data quantitatively.

Students of psychiatric social work will need additional courses in developmental psychology and in mental disease. Their practice will be in psychiatric social work and they will throughout their training emphasize detailed study of individual behavior.

Methods of Instruction

The classroom work should place comparatively slight dependence upon formal lectures. The medical subjects, particularly those dealing with disease and with bodily functions should be elucidated by demonstration in ward, clinic, or laboratory. Informal lectures, followed by questions and discussions, appointed reading on which class discussions are based, should be utilized, and above all, the project method whereby students are assigned problems which they must work out with the instructor in class or individually.

It is essential that there be continuity of instruction.

For purposes of correlation between the classroom work and the practice, the students should be required to bring into the classroom accounts of cases or problems which come up in their practice, which illustrate or raise questions concerning the subject matter of the academic instruction.

Miss M. Antoinette Cannon, executive secretary of the committee.

It is the opinion of the committee that the training for hospital social work should, whenever possible, be under university auspices, and that a special school or division of this university should be constituted, dealing with training for socal work. Hospital social work would be one branch of the training given in such a school.

Must Adapt Course to Varied Field

Social work as an assistant to medical service appears in several different relations. Social workers are needed in organized social service departments of hospitals and clinics, but medical organizations which are too new or too small to possess social service departments need, nevertheless, to carry on social work for the benefit of their patients.

In outlining the course in training in hospital social work, therefore, there should be held in mind the needs of those who intend to enter social service departments in hospitals and clinics, and also the needs of those who will practice medical social work in connection with other activities. The committee has outlined a general course of training for hospital social work, appreciating that such a course must be adapted flexibly to the demands of students and professional workers of varied preliminary training, different practical experience, and different future fields of work; and that elements of the course may be found useful parts of other training of related vocational groups.

Discussion of the Proposed Course

From friendly critics to whom the preliminary draft of the proposed curriculum was submitted last spring, and those to whom the present draft was submitted this autumn, certain outstanding criticisms have been received, to which attention should be given. The chief objections raised to the proposals of the committee have been (1) the course is too long, (2) the entrance requirements are too advanced, (3) taking into consideration the above points and the general subject matter and method of the course, the standard is too high to attract a sufficient number of students, (4) insufficient provision is made for students who had not previously had a nurse's training, to acquire familiarity in dealing with the sick and with methods of personnel of medical institutions, (5) the amount of medical instruction offered is insufficient and likely to be a mere smattering for those who have not previously had a nurse's training, and (6) the reverse criticism is made with equal force, that too large a proportion of the course is given to medical instruction, even for those who are trained nurses, in consideration of the fact that the essential technique required is social, and not medical.

The committee has weighed with special care the six major criticisms above listed. With regard to the first three, which may be taken together, the committee is of the opinion that these criticisms are based on two mistaken points of view; (1) that the need of the field is for a large number of workers rather than for workers qualified to meet the most exigent present demands, and (2) that a course of high standard attracts but few students.

Is the Course too Long?

The committee is furthermore of the opinion that a course of two years in length is the minimum standard in order that there be sufficient time to acquire the points of view and the working habits which hospital social work demands, and which, in their nature, can not be imparted to the student in a moment. They must be the fruit of continued contact in the field and in the classroom with certain types of facts and certain groups of professional workers and patients with whom the student is engaged. Time is essential for the absorptive processes. This is particularly important in hospital social work at the pres-

ent time, since there are many students with previous professional experience who have to acquire the point of view and the technique of a new vocation.

Should Students Live in the Hospital?

After much discussion, the committee has come to the conclusion that a period of residence in a hospital is not a necessary part of the training of a hospital social worker. The large amount of practice work required in the proposed course, the major part of which is in the social service department of a hospital or clinic, will bring the student for a large part of the working time for at least one year, into continuous contact with the personnel and conditions of a medical institution. It is believed that there is insufficient reason for adding to this a requirement as to residence.

Too Much or Too Little Medicine?

The two conflicting criticisms, that on the one hand the course gives only a smattering of medical information, and on the other hand that it has relatively more than hospital social workers require, must be answered together and in two ways. In the first place, no course within reasonable limits of length can include sufficient information on any subject to suit the specialist in that subject; in the second place, the committee believes that the criticism that the course is insufficient in medical subject matter arises chiefly from a misunderstanding as to the kind of medical subject matter which should be taught.

Conclusion

It is the committee's hope that this report on the proposed curriculum will be brought to the attention of the educational institutions throughout the country which are interested in the training of hospital social workers, and that practical steps may be taken to try out the recommendations of the committee, by the modification of existing courses, or the establishment of new ones in the directions herein indicated. The test of an educational program comes in the laboratory of practical experience with the student in the classroom and in the field. The committee's curriculum includes (1) a larger proportion of medical subject matter and of practice work than is at present offered by most of the schools of social work; and (2) a much larger proportion of training in social case work and of supervised practice in social work than is offered by some of the university training schools and nursing schools. The value of our recommendations must be determined by the tests of practice.

It is recognized that conditions in universities and schools training hospital social workers vary widely, that no standardized or uniform curriculum is at present conceivable. The field of training for hospital social work is, in a measure, one of educational experimentation, and the committee offers its report with the desire that its suggestions may aid existing schools in the advancement of curricula and methods, and that it may be suggestive also to those who are considering the inclusion of social subject matter and methods in the curricula of schools of medicine, public health and nursing.

In presenting this report to the trustees of the American Hospital Association, the committee trusts that its report will be accepted and the committee discharged. The present committee has fulfilled the function for which it was appointed. It would seem, however, that some service might be rendered by a committee, primarily of representatives from the educational organizations now offering training for hospital social work, which would serve as a medium for intercommunication so that each organization may learn from the others the results of its experimentation in subject matter and method. The committee believes that training for hospital social work will proceed more rapidly, will be made more self-conscious and more helpfully critical, if some such cooperative committee among these educational institutions were in existence.

PUBLIC HEALTH SERVICE EMPLOYS MANY WOMEN

In proportion to its size, the personnel of the United States Public Health Service probably includes more highly trained and specialized women than any other branch of the Federal Government.

Highest on the list stand two officers holding commissioned rank in the reserve—Surgeons Lydia Allen DeVilbiss and Josephine Baker. Next in rank come a number of scientific and professional women, all or most of whom are physicians, though some are classified by other titles. Among these are acting assistant surgeons Blanche Sterling and Edith B. Lowry, Viola Russel, pediatrist, and Elizabeth B. Reid—all belonging to the child hygiene section; Ida A. Bengston, sanitary biologist; Alice C. Evans and Mrs. E. M. A. Enlows, bacteriologists; and Mrs. S. C. Brooks, assistant biologist, all belonging to the hygienic laboratory; Gertrude Seymour, president of the American Women in Public Health, and Drs. Daisy Robinson and Edith Rabe, regional consultants, all belonging to the venereal diseases division.

Several large groups of highly trained women have been organized in the Public Health Service. Among these are the reconstruction aides, most of whom have had college training or its equivalent, and all of whom are of unusual ability and character. These are stationed at various hospitals of the Service throughout the country. Their task is to help maimed soldiers to regain control of injured muscles and nerves or of dormant or deranged mental faculties, by appropriate physical exercises (physiotherapy) or by curative and diversional occupations (occupational therapy). The aides, who are headed by Miss Marian Morriss, number about four hundred, to whom others will be added as qualified applicants can be found.

Vying with the reconstruction aides are the dieticians, whose section was organized about a year ago to take over from the pharmacists the victualing and food administration of the scores of military hospitals now handled by the Public Health Service. All the members of the section, which is headed by Mrs. H. B. Corsette, are graduates of schools of household economics, and are thoroughly trained and experienced in all matters relating to dieting. When fully recruited, the personnel will be about two hundred.

The nurses' corps, headed by Miss Lucy Minnegerode, consists of nurses who have been highly trained in everyday hospital work and a large proportion of whom are specialists in particular lines, such as mental and nervous diseases and tuberculosis. The corps today numbers 1,400 and needs 300 more. All applicants must, however, be graduates of recognized training schools, and must be registered either in the state in which they live or in that in which they were graduated.

Another body of nurses, 165 in number, who work in clinics and miscellaneous health activities under the supervision of Miss Ann Doyle, specializes in venereal disease treatment.

"Private nurses are sometimes spoilt, sometimes put upon. Let her not allow spoiling to spoil her, and let her learn from being put upon not to put upon others."—Florence Nightingale.

COMMITTEE ON FORMS AND RECORDS DISCUSSES THE ANNUAL REPORT*

TO PROVE of greatest value an annual report should at least serve the following purposes:

1. As a public record to the community of the institution's activities, both financial and professional.

2. As a permanent record to boards of trustees, auxiliary committees and other supporting bodies.

3. As a basis for allocating subsidies in communities operating under a Community Chest or similar subsidy plan.

4. As a public recognition of contributions or donations.

5. As a permanent record and public acknowledgment of the service of various professional men and women connected with the hospital.

6. To convey to the medical profession in general, information concerning professional services rendered.

7. To convey information to other allied groups, such as nurses, social workers, dietitians, etc., concerning such hospital activities, as are of interest to them.

8. To convey information to the hospital and public health fields concerning the activities of the hospital and for purposes of comparison.

A review of a large number of annual reports prompted the suggestion that if they are to serve their purpose of publicity, more attention be paid to their compilation to improve their attractiveness and promote their appeal. The following points are worthy of careful consideration: Size of page, individuality of cover, typography, arrangement of contents, and the liberal use of illustrations, showing various activities.

Dr. A. C. Bachmeyer's committee on forms and records presented a second report.

Although it is impossible for the committee to submit a standard annual report that will serve every hospital or community it desires to submit an outline that includes information of prime importance. This outline is not all-inclusive and can readily be amplified to meet the needs of individual institutions without sacrificing any essential details.

Outline of Annual Report

1. Table of contents.

2. Names of board of trustees, officers, committees, auxiliary groups, etc.

3. List of attending medical staff, designating rank and service.

4. Acknowledgment of gifts (form and type, as determined by the board of trustees).

5. Report of president of board of trustees.

6. Report of treasurer.

Corporation accounts. (Show present and part year figures for purposes of comparison.

Statement A.—Assets and liabilities, showing all capital holdings, investments, etc.

Statement B.—Income and expenses.

Operating accounts.

Statement A.—Income (compare two years). Show in detail, as follows, according to Scheme 1 or Scheme 2 of the American Hospital Association standard chart of accounts.

Statement B.—Expenses. Show distribution of expenses (compare two years) in detail as follows, according to American Hospital Association standard chart of accounts.

Statement C.—Resume of operating accounts (compare two years):
Total income.
Total expense.
Surplus or deficit.

7. Report of administrative officer:

The first part of this section should contain tables pertaining to certain vital statistics and the remainder should consist of detailed reports concerning the activities of the various departments of the hospital, such as nursing, social service, dietary, pharmacy, laboratory and the domestic and mechanical departments.

8. Statistical tables (compare two years).

Table A.—Service rendered:
Census (last day, previous year); patients admitted; births; total patients treated; patients discharged; deaths; census (last day, present year); patient days' care; normal; maximum census (date); minimum census (date); average daily census; average patient stay in hospital; number deaths within 48 hours; number deaths (institutional); mortality rate (excluding 48 hours deaths); autopsies (number); operations (number of major and minor); total hospital operating expenses; per diem capita cost.
Out-patient department: Number of visits; number of new patients; total out-patient department operating expenses; average cost per visit.

Table B.—Financial classification of service (compare two years). Admissions and patient days of: Pay patients, part-pay patients, free patients; totals.

Table C.—Patients denied admission (compare two years). Lack of accommodations; referred to non-staff physicians; communicable diseases; unsuitable (list causes); hospitalization unnecessary; totals.

Table D.—Analysis of service (compare two years). Medical, surgical, obstetric, specialties enumerated as to number of patients, days' care, per cent days' care.

Following the above statistical tables, various departmental report should be inserted.

9. Report of attending medical staff:

A. A brief review of the work of the attending staff, including lists of special studies made and articles published by the staff—clinical, laboratory and x-ray. In larger hospitals this section would probably be elaborated to show the various professional departments.

B. Professional statistics. The existing medical nomenclatures are not sufficiently comprehensive and are lacking in uniformity. Until a uniform nomenclature can be compiled through the collaboration of allied interests, the committee does not feel that any one of them can be recommended as a standard. Therefore, it does not recommend the publication at this time of professional statistics.

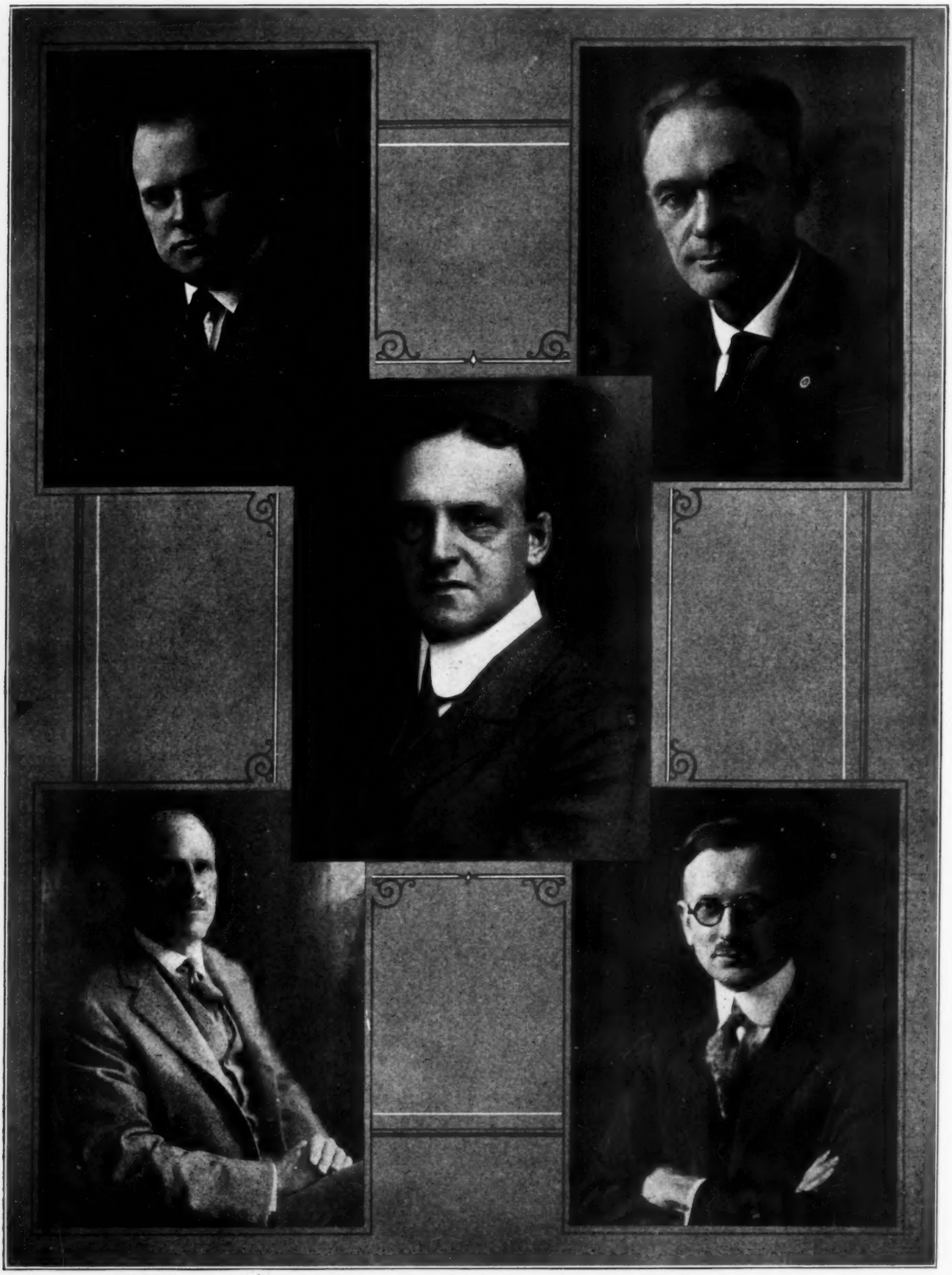
The committee believes that the use of standard tables of statistics, such as those suggested, the filing of such report with a central agency, such as the Hospital Library and Service Bureau, and the compilation of the accumulated statistics would make available a volume of accurate data concerning hospitals that would be of great value to the field.

Going in with your mind set on winning is the first essential to making a success in any work you may undertake. Half-hearted effort will not take you very far in any line of endeavor. If you think enough of a job to accept it, think enough of yourself to do your work the best you can and you will come out on top in the final count. Intelligent effort and close attention to business will win out in this or any other line, and the success of the best man in every organization is the final proof that leaves no room for argument.

Self-sacrifice is well enough but don't give yourself to be melted over for the tallow trade.—George Eliot.

*An abstract of the second report of the Committee on Forms and Records composed of A. C. Bachmeyer, M.D., F. E. Chapman and John F. Bresnahan, M.D.

THESE CHAIRMEN GAVE INFORMATION AND ADVICE ON THE EXPOSITION



They are: Dr. C. W. Munger (upper left) Dr. W. P. Morrill (upper right), Dr. S. S. Goldwater (center), Dr. H. W. Hersey (lower left), Dr. A. B. Denison (lower right).

NEWER TENDENCIES IN HOSPITAL CONSTRUCTION*

AMONG the helpful reports of the conference was that of the committee on buildings-construction, equipment and maintenance—which is given in full as follows:

The coupling of equipment with construction, and of maintenance with both, is perfectly logical. The mechanical equipment of a hospital building is inseparable from its construction, and notably affects the cost of construction. While the extensive use of mechanical equipment increases the cost of maintenance of the building, considered merely as a building, mechanical equipment, if intelligently chosen and properly installed, tends by simplifying and improving service to decrease the cost of administering the hospital. For this reason the original cost of serviceable equipment should not be regarded as a deterrent to its introduction.

The plans and specifications of a hospital represent a choice of means and may be said to be an expression of the opinion of the building committee, its technical adviser (superintendent or consultant, as the case may be) and the architect. In the planning of a hospital building as well as in the writing of the specifications experience should have a voice. The items which appear in the financial reports of hospitals under the head of "house and property expenses" and all other items of expenditure which are affected by the character of the hospital building and its equipment should be carefully and repeatedly analyzed by those who are engaged in hospital construction, for in this way only is it possible to arrive at an understanding of the ultimate or service value of the materials used.

This committee has been requested to speak of the "best policies," of the "consensus of opinion" and of "present standards" in the special field of construction.

Since planning logically precedes construction and is bound up with it, it cannot very well be ignored in this report, but the briefest mention only can be made of this phase. Among the standards, practices, and tendencies observed in current hospital planning, the following are deemed worthy of mention:

a. A growing disposition to inquire into the needs of a community before making plans, thus avoiding wasteful duplication and overlapping. The committee strongly endorses such inquiries.

b. A marked tendency toward concentration in planning, the object of which is to economize in the use of building materials, and to facilitate medical, administrative, nursing and domestic service.

c. The development of general plans through the putting together of the plans of individual departments, each conceived from the standpoint of precise needs; in other words, scientific, synthetic, technical planning rather than the adoption of loosely conceived general schemes, dominated by conceptions of architectural design. With the new point of view, architects generally are now in accord.

d. Theoretical emphasis on flexibility in anticipation of future expansion as well as of changing needs (with lapses in practice which, unfortunately, are all too frequent).

e. A widespread demand for convenient facilities for outdoor treatment. In practice there is observable a shifting of emphasis from roof to veranda as a means of outdoor treatment and the consequent lifting of the taboo on pitched roofs, which, while not universally approved, are reappearing in important multi-storied hospital buildings.

f. A demand for a reasonable measure of privacy for patients occupying semiprivate and ward beds, resulting in the subdivision of a considerable part of large open ward of former days into small wards, individual cubicles or even small individual rooms.

g. A more liberal use of plumbing fixtures, especially of individual watercloset in connection with private rooms, and of washbasins in both wards and private rooms. There is not, however, a proportionate increase in the number of private baths.

h. The use of single rooms in nurses' homes for both graduate and pupil nurses.

i. An increase in the allotment of space in nurses' homes for teaching purposes (lecture rooms, demonstration rooms, science laboratories, study rooms, libraries, etc.)

j. Efforts to obtain central and accessible locations for diagnostic laboratories and for treatment rooms of every description.

k. The reservation of considerable office space for social service and follow-up work.

l. Failure on the part of many medical staffs to urge the allotment of adequate space for out-patient work.

m. A diminishing use of small dumbwaiters for food service, large service elevators being required for the more modern types of heated or insulated food carriages.

n. The reconstruction of the whole question of centralized versus decentralized nursing service, experimenters being disposed to transfer a part of the fixed equipment of pantries, sink rooms, utility rooms and chart rooms, away from the traditional nursing station of the individual ward unit, and to locate this equipment centrally to the whole hospital. These measures are based on a theory of administration which involves the separation of nursing service into two parts, namely, actual bedside work, and the preparation of utensils, dressings, medicaments, and indeed of all materials and supplies which are used at the bedside or administered to the patient.

o. A feeling that serious efforts should be made toward the standardization of fixed equipment. Standardization is favored by the open-mindedness, the disposition to investigate or scientific curiosity, and the readiness to imitate, which may be said to be characteristic of the American mind. It is also favored by the growing recognition of hospital planning as a highly complex special art or discipline. Forces which impede or obstruct standardization are indefiniteness of purpose on the part of hospital boards, the employment of inexperienced hospital designers, the desire of hospital architects, superintendents, and consultants to achieve distinctive results, and strong commercial competition among manufacturers of building material and equipment.

Practices in Construction and Equipment

Turning now to construction and equipment proper, the following are noted as prevailing opinions, practices, or tendencies:

1. Insistence on fireproof construction, with or without legal compulsion.
2. Simplicity and economy in exterior design.
3. A certain hesitancy to use unmodified ferro-concrete construction on account of the dangers of excessive sound transmission.
4. The disappearance of the wood floor, and a lack of unanimity concerning the most satisfactory substitute for it (this subject is exhaustively dealt with in the report of another committee).
5. The occasional substitution of solid plaster for hollow tile in the construction of interior partitions.
6. The predominance of metal interior trim, which, however, is frequently omitted to reduce slightly the cost of construction.
7. The use in special interior locations of sound absorbing material and of soundproof doors.
8. An increasing demand for built-in features and specialties, such as specimen closets, drying closets, garbage closets, clothes chutes, fire hose cabinets, supply and instrument cabinets, etc.
9. The use of double hung sash in window construction and the constant improvement of devices for increasing the area of ventilation in summer and for facilitating window cleaning.
10. The substitution of interior or enclosed fire stairs for exterior fire escapes.
11. The omission of transoms over private room doors (cross ventilation being obtained by means of secondary dwarf or screen doors of light construction).
12. The use of brackets or wall supports in place of legs or floor supports for fixtures.
13. The installation of independent electric generating plants in nearly all except the smallest hospitals.
14. The more frequent use of petroleum as fuel.
15. Heating by direct radiation in preference to indirect.
16. Increasing use of refrigerating systems in hospitals of moderate size.
17. Attempts to eliminate overhead skylights for the natural light of operating rooms, and the substitution of enormous areas of vertical north lights.
18. The use of secondary emergency lighting (in addition to the standard electric lighting) for the artificial illumination of operating rooms.
19. The willingness of laboratory workers to accept artificial lighting for microscope work.
20. A preference for artificial illumination for colorimetric tests in chemical laboratories.
21. A demand for facilities for the examination of x-ray plates by daylight.
22. The use of portable vacuum cleaning machines in preference to pipe systems connected with high powered central machines.
23. The use of central destructors or incinerators for general waste disposal.
24. The use of local incinerators where the prompt destruction of infectious material is deemed important.
25. The use of a great variety of mechanical and electrical devices, such as call systems, telephone connections, the telautograph, radio connections, etc.
26. Emphasis on the direct ventilation of wards and patients' rooms, with the selective use of mechanical ventilation (especially exhaust ducts with fan equipment) for the ventilation of operating rooms, out-patient rooms, lecture rooms, kitchens, laundries, sink rooms and closets, toilets and baths, laboratories, autopsy rooms and animal rooms.
27. The widespread use of tiled wainscots for service rooms of all kinds.
28. The use of tile wall finish in receiving wards and, to some extent, in children's wards.
29. Insistence on the screening of all hospital buildings.
30. A recognition of the dangers inherent in the use of x-rays and the redoubling of preventive measures, such as the protection of wires and the special treatment of floors, walls and ceilings.
31. The introduction of warm colors for interior finish and decoration.

Seek the welfare of the human race.—Tarascon.

*Report of Committee on Buildings prepared by S. S. Goldwater, M.D., chairman; R. G. Broderick, M.D.; Frank E. Chapman; Pliny O. Clark; C. G. Parnall, M.D.; John M. Peters, M.D., and Wiley E. Woodbury, M.D.

REPORT OF COMMITTEE ON GAUZE RENOVATION AND STANDARD DRESSINGS*

THE report of the committee on gauze renovation and standard dressings is preliminary in nature; it is based not upon a large collection of observations, but on the experience of a small number of Cleveland hospitals. It is not a detailed recommendation of what *should* be done by all hospitals but rather an exposition of what *can* be done and the results that *can* be obtained. That these results are wholly desirable probably could be construed as a recommendation.

Reclamation of Gauze

In considering gauze reclamation the primary proposition to be taken up is its practicability in relation to other hospital activities. In other words, since the washing of gauze results naturally in more or less accumulation of the washed product, it must be determined that this gauze can be used in place of new gauze, that its use results in the saving of other materials more expensive, or that the washed gauze can be used more efficiently than some other material. The uses of washed gauze are really very extensive and should be developed to the highest degree possible without creating artificial demands or uses. It is the firm belief of the committee that a fair investigation of the merits of gauze renovation will show that it is practicable in a great majority of hospitals, if not in all.

The question of washing gauze is probably more difficult if the hospital executive does not have access to the experience of other hospitals. The figures compiled by one Cleveland hospital show that there was saved by washing gauze $500 per month. These figures represent very closely the experience of other hospitals that are washing gauze.

If it is found to be practicable and advisable to wash gauze, the next step is to determine the type of gauze to be used, in other words, the count of gauze that stands washing best. Rather extensive experiments were carried out by the committee to determine this point, the results of which are shown in an exhibit of washed gauze handled under a variety of conditions. The committee feels that its series of samples shows beyond a doubt that the higher counts of gauze stand the wear and tear of washing better than the low counts; and all things being equal, the higher counts are more desirable for reclamation purposes.

Before accepting this statement at its face value, however, every hospital contemplating the reclamation of gauze must determine one basic thing. It is obvious that there must be a balance between new gauze and washed gauze, insofar as its use is concerned. To be more explicit, a proper gauze balance is a point where the new gauze being put into circulation through various channels just supplies the normal decrease in the supply of washed gauze and no more. The committee's exhibit shows that the shrinkage of reclaimed gauze is a controllable thing, largely dependent upon the weight of the gauze used.

The committee's recommendation, then, as to weight of gauze is to use the lowest count gauze that will wash a sufficient number of times to preserve the balance between new and old gauze. Every effort should be made naturally to use washed gauze in the place of more expensive material but this use of reclaimed gauze should not be forced to the point of creating new demand or uses for gauze when some other material would be cheaper and more efficient. The committee recommends the use of 24-20.

The next logical step to be determined in considering the advisability of washing gauze is the method of reclaiming. This factor varies in detail in different hospitals since it is dependent upon so many personal factors; essentially most methods are the same. Very briefly, the process consists of soaking the gauze over night in cold water in a washer reserved for gauze washing. In the morning the gauze is washed in several changes of cold water, then several of hot water, bleached and dried in the centrifugal drier. Repeated bacterial tests have shown that the gauze is sterile at this point but usually, as a matter of extra precaution, it is run through the formaldehyde autoclave. It is then pulled out straight in the gauze room, wrapped in packages and sterilized again.

The committee took the standard specifications drawn up by the Cleveland Hospital Council as a basis for its investigation of standard dressings. Four basic sizes were decided upon by that council: 36x36, 36x18, 18x18, and 12x12.

One hospital in particular made a very careful study and analysis of the use of gauze with the following results: The consumption of new gauze for the year June 1921-22 was 124,400 yards. Of this amount, 115,255 yards went into the manufacture of dressings from basic sizes; or the dressing made from the four standard sizes of cut gauze utilized 92 per cent of the new gauze used by this hospital. These figures, while they are not based on the experience of many hospitals and hence can hardly be taken as the basis for a general statement, seem to the committee to be a convincing argument of the practicability of standardized dressings. It was further learned that in this hospital of the 115,000 yards of gauze used in the manufacture of standard dressings, 94,197 yards went into the manufacture of surgical sponges or about 76 per cent of the new gauze used. So since surgical sponges comprise such a large part of the dressing requirements, they were taken as typical of all the dressings and were studied more in detail.

But even if it is shown conclusively that it is practicable to use standardized dressings in all hospitals, just wherein lie the advantages to be secured by their use. In general, the answer to this perfectly natural question is that gauze manufacturers with all their mechanical equipment can perform certain mechanical processes more rapidly and consequently more cheaply than a hospital can do the same work by hand. The adoption of standard basic sizes is the first step toward enabling the manufacturers to set up the machine adjustments necessary for this. The ultimate result may be that manufacturers prepare these standard dressings and carry them in stock, but the committee does not stand ready to make any such recommendation at present. It has conducted certain preliminary studies, however, that are interesting as suggesting the possibilities in this direction.

The results of these studies seem to indicate that the machine cutter saves quite an appreciable amount of time over the method of cutting by hand, but the saving in time effected by the use of package-cut gauze is even more striking.

In concluding this report, the committee feels that inso-

*Read by A. B. Denison, M.D., chairman.

far as gauze renovation is concerned, it is practicable in the vast majority of cases, and the committee wishes to urge its careful consideration by every one responsible for the management of a hospital.

To turn to standardized dressings, the committee feels that the results obtained so far justify its belief that a widespread study of the possibilities of standardized dressings would result in an enormous saving to hospitals of the country and asks the cooperation of the association in compiling the necessary information.

COMMITTEE ON FOOD EQUIPMENT PRESENTS REPORT OF GENERAL INTEREST*

THE subject of the construction and proper operation of the dietary department of a hospital is such a vast one that a report of this sort cannot attempt to cover it.

The location of the kitchen is a matter which has often been debated, the three locations most used being: the ground floor or basement; the top floor of the hospital; a separate building. Each one of these locations has its advantages, and the committee holds no particular brief for any one type.

The architectural divisions into which the dietary department is separated can be roughly defined as a generality but the kitchen must by all means be designed to meet the requirements of the institution which it is to serve. Divisions which the committee would arbitrarily set for a hospital of 150 to 200 beds are as follows:

1. Main kitchen—36x40 ft.
2. Diet kitchen—23x27 ft., with dietitian's office adjoining, 10x12.
3. Dishwashing room—20x25 ft.
4. Ice storage and ice cream room—12x12 ft.
5. Large cold storage space in connection with general storeroom, but utilized mainly for foods for the dietary department, which can be requisitioned as needed—25x20 ft.
6. Three cold storage rooms opening into anteroom in direct connection with the kitchen—each 8x10 ft—with convenient shelves and hooks:
   1 for fruits and vegetables.
   1 for dairy products and eggs.
   1 for meats.
7. One small cold storage space about 2x4 ft. for sea foods.
8. One bread and pastry room about 10x15 ft.
9. Convenient elevators for transportation of food.
10. One diet kitchen—12x18 ft.—for each unit (20 to 35 patients).
11. One pupil nurses' dining room with serving room.
12. Three dining rooms for the various divisions of the staff (with serving room).
14. One dining room for male employes } with common serving room.
15. One dining room for female employes }
13. One dining room for patients' friends.
16. One milk room.

The committee has made no attempt to suggest grouping of these rooms, or arrangement in the rooms of the various devices which this report will bring to your attention. Those details must be determined separately for each hospital.

Labor Saving Devices Recommended

Labor saving devices permit the hospital to economize, both as to payroll and as to amount of foodstuffs used. It is the opinion of the committee that the following should be found in every hospital kitchen:

An electrically driven machine or machines which will chop meat and vegetables, and which may be used as a bread crumber.
A butter cutting device which makes it possible to use bulk butter rather than the more expensive print butter.
An electrically driven meat slicer.
An electrically driven bread slicer, with efficient safety devices.
An electrically driven vegetable parer.

Fireless cookers used overnight in the preparation of cooked cereals are economical and efficient.

It is advisable that as much cooking equipment as possible be heated by steam. Both copper and aluminum steam heated equipment have been found satisfactory. A recent innovation is a low temperature vapor cooker which is heated by means of steam but which does not employ live steam as a cooking agent. This new method would appear to merit consideration and further trial.

Coal gas is perhaps the most desirable fuel for use in preparing food which must be baked or roasted, or cooked on top of the stove.

A few years ago we seemed to hear more of the use of electricity for cooking than we now do. The use of electricity has been complained of as being slower and more expensive than gas. Improvements in manufacture will no doubt increase the speed of cooking, and the cost of electric power in the institution under consideration will no doubt determine whether the use of electricity is practical. An appliance which has come into quite general use within the past few years is the electrical bake oven for breads and pastries.

In localities where natural gas is plentiful it has been found admirable for kitchen use.

The gas, or other type of stove, should be of ample size. It should be properly located from the point of view of unnecessary steps and should have as few projecting surfaces as possible, so as to simplify the matter of cleanliness. The stoves, as well as all the heated equipment, should be grouped under one or more hoods which are connected with powerful ventilating fans for the purpose of carrying away heat and odors. Electric, gas, or steam coffee machines should be installed in a battery. There should be at least two urns in case of difficulty with one, and in most hospitals it is desirable to have three or more urns for coffee and one or more for tea and cocoa. In the majority of cases steam will be found most suitable for heating these urns.

Handling of Milk Important

The handling of milk, cream and ice cream in a hospital is a matter which requires earnest attention. The hospital executive who permits the use of old fashioned milk can and dipper for milk to be used for drinking purposes is probably making a grave error. Moreover, he is at fault if he does not periodically check the purity of the milk supply by means of bacteria counts made in the hospital laboratory. It is impossible for the committee to recommend any one method of caring for milk. Some hospitals may wish to purchase certified milk entirely for drinking. Others may prefer the pure raw milk and pasteurize it themselves, still others may purchase milk already pasteurized for general use. The committee, then, can only recommend that the dietitian and the superintendent of the hospital know and assure themselves of the purity of the milk when received by the hospital, and that they take every precaution to see that it is not further contaminated or neglected after it is received.

The electric mixing machine is indispensable in the modern institutional kitchen. It can perform so many services for the cook that she, perhaps, considers it her greatest boon.

There can be no doubt that the modern type of dishwasher is a vast improvement over hand washing. For

*Presented by C. W. Munger, M.D., chairman; F. R. Nuzum, M.D.; E. T. Olsen, M.D.; Miss Rena Eckman; C. S. Woods, M.D., and Miss Alice E. Thatcher.

hospital use, in the opinion of the committee, the automatic dishwasher which does not sterilize the dishes fails to perform a function which is most important.

Food conveyors are of many types. By some the steam table is preferred with containers sent up on the elevator and placed in the steam table on the ward. Still others use the food cart, heated by hot water or by electricity, or the newer type of food cart constructed on the principle of the fireless cooker or the vacuum thermos bottle. The conveyor heated with hot water has been criticized because of inefficiency and because of its greater weight which requires more current for the elevators. The electrically heated device has been said to overheat the food at times and to give it a warmed-over taste. The third type of food cart has been in use for a shorter period. Either for that reason or because it is superior, we have heard fewer criticisms of this type. It is surely true that it consumes no fuel, that it does not have the disadvantage of great weight, and it cannot overheat the food because the latter is kept at exactly the temperature at which it is put in.

Problems of the Diet Kitchen

The dietitian's kitchen, if conveniently located, need not duplicate all the equipment found in the main kitchen, although a certain amount of duplication is inevitable. The diet kitchen, as well as the main kitchen, should be conveniently located to the service elevators or dumb waiters which communicate with the various nursing units. If the food cart system is to be used these elevators should be so planned as to accommodate one or more of them.

Convenient to both kitchens we should place the cold storage rooms. These rooms should be well refrigerated, should be of ample size, but not so large as to be wasteful of the refrigerant, should contain convenient shelves, hooks or tables, and should be so constructed inside as to make absolute cleanliness easy.

The diet kitchen proper should contain such general cooking equipment as is necessary but should be particularly designed for the scientific preparation of special diet orders.

In order that the hospital diet kitchen may be most efficient, it is first of all important that there be a thorough understanding of dietetics on the part of the physician. A hospital is not prepared to render an efficient food service unless its dietetic department can, and does, teach dietetics to physician, and patient, as well as pupil nurses. The physical equipment of the kitchen must permit of the satisfactory preparation of both general and special diets economically, and there must be a transportation system that gets the food, warm and palatable, to the patient. There must be a plan of cooperation between the physician, dietitian, nurse, and patient so that orders given are accurately carried out and recorded.

In the preparation of special diets and especially of diets for diabetic, nephritic, hypertension, gout and obesity patients, it is well to have a section of the general kitchen set aside for this work.

The personnel of the dietary department is the most important consideration. The committee has not attempted to recommend any particular organism other than to insist that the chief dietitian control the entire food problem of the institution, and that she be not restricted merely to the preparation of special diets. Assistant dietitians should be provided if needed. The presence of pupil nurses and pupil dietitians in the department has a very desirable effect upon the standard of work, and stimulates the superior officers to set the best possible example. Efficiency of employes is all important. Salaries should be as generous as possible, and the department should be so managed that there is not the constant change in personnel so often seen.

The committee recommends a detailed accurate accounting system for the dietary as well as other departments. The dietitian must be able to analyze cost figures if she is intelligently to eliminate carelessness and waste.

WHY GAUZE RENOVATION PAYS

In the following table, comparable steps in gauze use are indicated and balanced where an equality exists. This table constituted one of the valuable supplements to the report of Dr. A. B. Denison's committee on gauze renovation and standard dressings which were being distributed from the exposition committees' booth.

NEW GAUZE

1. Delivered to gauze room or operating room from store room.
2. Opened, laid out and cut into sizes for dressings.
3. Made into Dressings.
4. Made into packages, counted and stacked.
5. Wrapped and marked.
6. Sterilized.
7. Delivered to Wards.
8. Used as dressings.
9. Collected.
10. Delivered to incinerator.
11. Burned.
12.

WASHED.

1A. Delivered to gauze room from Laundry.
2A. Pulled.
3A. Made into Dressings.
4A. Made into packages, counted and stacked.
5A. Wrapped and marked.
6A. Sterilized.
7A. Delivered to Wards.
8A. Used as dressings.
9A. Collected.
10A. Delivered to incinerator.
11A. Washed.
12A. Autoclaved.

Balance against No. 2.

It is noted that No. 2A is greater than No. 2, so we have considered No. 2 in comparison with 12A. All items then are balanced except 2A (Pulled). This item then must be considered in comparison with the cost of new gauze to take the place of the washed gauze used.

The figures indicating this relation in one hospital, are:

Gauze used .....115,255 yards new,
772,655 yards washed.

Total .....887,910 yards.

Cost When Renovated

New gauze,
115,255 yards @ .032 .....$3,668.16
Labor in gauze room, ... 3,900.00

Total cost $7,588.16
Saving by washing gauze $17,852.50

Cost When Not Renovated

New Gauze,
887,910 yards @ .0285 .....$25,440.66

"What is it to feel a *calling* for anything? Is it not to do your work in it to satisfy your own high idea of what is the *right*, the *best*, and not because you will be 'found out' if you don't do it?"—Florence Nightingale.

COMMITTEE URGES STANDARDIZATION OF CLINICAL AND SCIENTIFIC EQUIPMENT AND SUPPLIES*

IN THE preparation of a report such as this, embodying as it should a very general survey of the field of clinical and scientific equipment, one is faced first of all with one great outstanding fact, the multiplicity of similar types of equipment. It is almost impossible for every manufacturer to carry in stock an adequate supply of every item listed in his catalogue, and in most cases the equipment is made or assembled after the receipt of the order. In other words practically every large hospital order for equipment is "special work." This situation must be reflected in the price and in no way can it be credited to the manufacturer. Individual hospitals themselves are responsible for the large variety of similar types of hospital equipment and apparatus.

The remedy for this condition likewise lies within the grasp of the various individual hospitals through the medium of that much abused term "standardization." Of course, it must be admitted that standardization of equipment has its limits of practicability, and that this limit is sooner reached in scientifie and clinical equipment than in almost any other general classification of hospital supplies. So keeping that fact in mind there certainly are basic standards that should be set for hospital equipment which would give the groundwork so essential in the selection of equipment.

It is the rather generally accepted plan for the hospital superintendent to familiarize himself to a certain extent with what other hospitals are using in the way of equipment and then to select the apparatus that most closely meets his need as he sees it. To do this without familiarizing himself with the background obtaining in every hospital he investigates cannot lead to the most intelligent buying of equipment. All inquiry as to equipment should include an inquiry into the factors composing the situation leading the purchase of such equipment. It is more valuable to know the essential features of the background of the equipment than to know that X hospital uses so many pieces, so large, of such and such an equipment.

*An abstract of the report of the Committee on Clinical and Scientific Equipment and Supplies presented at the twenty-fourth annual conference of the American Hospital Association by A. B. Denison, M.D., chairman.

The responsibility for the great variety of hospital equipment of similar nature which is on the market rests largely with the hospitals themselves and the responsibility for changing this situation also belongs to the hospitals.

The first requirement in the intelligent purchasing of hospital supplies is a thorough knowledge of the needs to be met by these samples.

Basic standards but not detailed specifications should be set up by some group competent to know, these standards to furnish the groundwork for considering the particular needs.

A knowledge of the "hospital composite" in other hospitals is more important in selecting equipment than the knowledge of merely what they have in the way of apparatus.

Lists of equipment submitted without any knowledge of the "hospital composite" are of very little value.

In purchasing surgical and laboratory supplies the superintendent must rely on his visiting staff for its judgment and must foster mutual confidence.

Since we feel that it is impossible to form an opinion intelligently as to the equipment needs of a hospital without of knowledge of background, we could not conscientiously prepare in advance any standardized lists of equipment for any hospital. Such lists have been prepared and are available—and probably serve as a very general guide in equipping a new hospital unit—but we doubt very much the desirability of including such lists in this report. A hospital is a composite of human beings trying to render humanitarian service to other human beings, and as such is not susceptible to rigid standardization in every particular any more than is the individual. The only way to judge the needs and the means of meeting those needs is by careful painstaking study in the light of all the background affecting those needs. May we not call this background the "hospital composite?"

The procedure of the hospital executive in determining the character and quantity of purchases, after a complete adjudication of all contributing factors, is basicly sound and practicable. In the purchase of many items of scientific and clinical equipment, one of these factors of "the hospital composite" assumes a very great importance, the fact that in these items are many that are very highly specialized and subject to changes in technique in diagnosis and treatment. In the interests of harmony and efficiency the director or superintendent must be prepared to go to reasonable lengths in trying to satisfy his professional staff. It may perfectly well be true that there should be standardization of such items of equipment, but the first step must of necessity be the development of a harmony between the executive and the staff and a willingness on the part of both to consider the proposition on its merits. The very real economies that can be effected by a larger use of standardized instruments and equipment are obvious. Manufacturers of surgical equipment would certainly operate more efficiently, with the consequent price of reduction, if they were relieved of the necessity of carrying in stock or in patterns and special dies the enormous reserve they are forced to carry on account of the diversified demand for instruments.

Another complicating factor in the purchase of surgical supplies is the relative short period of usefulness of many special instruments and apparatus due to the rapid changing of technique or other similar factors. The hospital executive must be prepared to discard for this reason much apparatus and many instruments still mechanically perfect, and purchase many new things if his hospital is to be kept to the point of greatest efficiency. In order to do this intelligently there must be a close cooperation between him and his staff, based upon mutual confidence. The most modern clinical and scientific equipment is part of their professional knowledge. The hospital director must draw on this fund of information if he is to keep his equipment to the point of greatest efficiency.

When we turn from a consideration of the items of equipment that must ultimately be used by the professional groups to the items that form part of the permanent equipment of the hospital, the situation is radically different. Steel furniture, for example is susceptible to the most rigid specifications, as to methods of construction, size of material, and thickness of metal and finish. The fact that a hospital may care to have a distinctive type or style does not change this fact at all for these are features that are basic and should be observed in any furniture regardless of the type or style. A larger purchasing of standardized pieces will most surely result in a lowered cost with no change in quality due to quantity production, but it is up to the hospital man to determine the price he is willing to pay for a distinctive type.

As an example of what can be done in the way of detailed specifications for some of these items, may I refer to the specifications for wheeled equipment,† and the basic specifications for sterilizers that have been prepared for the Cleveland Hospital Council. These specifications are too detailed to outline here, but I may say that they specify to an exactness the construction of wheeled equipment. The purchase of any wheeled equipment on these specifications would almost guarantee the purchaser against apparatus defective in design or material.

†These specifications are published in the Department of Equipment and Operation on page 364 of this issue.

LAUNDRY COMMITTEE OFFERS PRACTICAL AID TO THE SMALL HOSPITAL*

THE four points to be considered in the installation and operation of a hospital plant are: personnel, location and equipment, supplies and processes. In the smallest plant, suited for hospitals of 50 to 75 beds, it will usually be found that with the janitor or engineer to run the washer and extractor and even the flat work ironer, one woman will be able to handle the laundry, with perhaps some part time help to do part of the hand ironing.

All who have had experience agree that the best location for the laundry is a separate building but as this is hardly feasible for the small hospital it is suggested that it be located close to or connected with the boiler room, thus making it possible for the engineer properly to supervise the machinery or to assist in its operation. Likewise the boiler room usually is sufficiently isolated from patients' rooms that this location will prevent noise, steam and odors becoming a cause for complaint. But wherever located the space must be sufficient in floor area to provide wide passage ways for the handling of baskets, ample ceiling height, ventilation and light.

The equipment can hardly be discussed in detail in this report; suffice it to say that a washer, an extractor and a flat work ironer are the basic units and can be secured in sizes to meet the requirements of hospitals as small as 23 beds. One of the first units to be added after these three is a press, as it is at least four times as efficient as hand-ironing on those articles to which the flatwork ironer is not suited. Unless a large amount of personal work is done very little hand ironing will be necessary. For such as is done there should be provided electric irons preferably two for each board. In the larger laundries many accessory machines will be of service.

Supplies Often Source of Trouble

The matter of supplies is the one to which least consideration is usually given and which at the same time is the source of much dissatisfaction. And the first and most important supply is water. The nearer we can get to the old rain barrel, the happier will be our lot. Most city water supplies are not only hard in their natural state but are chemically treated to make them fit for human consumption. The lime contained in them unites with the soaps to form an insoluble lime soap which permeates the thread and produces that harshness which makes the linen so disagreeable to the skin and at the same time makes the fabric brittle and very materially decreases the life of the linen, because after all the real wear and tear on linen is in the laundry and not in use. Hard water likewise wastes supplies. According to one authority for each degree of hardness there is a theoretical soap waste of 1.3 lbs. per thousand gallons.

SOAPS. Soaps are a chemical compound of an alkali with a fat, with glycerine as a by-product. For laundry purposes chip soap has held the field for some years and many reliable brands are on the market. But even the reliable brands vary widely in water content, running from twelve per cent up to twenty per cent and if adulterated even more. The water does no particular harm but the careful buyer will object to paying soap prices for it. In the more recently introduced powdered soaps the moisture occasionally runs as low as eight per cent. In any case it is well to test purchases for moisture occasionally which can be done by weighing out a given quantity, say ten pounds, drying for 24 hours in the dry-room or even in a warming oven or hot air sterilizer and re-weighing. The initial weight in ounces should then be divided into the difference between the weights before and after drying in ounces and the quotient will express the percentage of water. Care must be exercised to take the sample from the middle of a freshly opened barrel as the soap near the surface always loses some of its water by evaporation, and would thereby give a false result.

ALKALI. Contrary to general belief alkali has no detergent action and is used only on account of its power of increasing the detergent action of soap. The only alkali

*An abstract of the report of the Committee on Laundry and Laundry Supplies presented at the twenty-fourth annual conference of the American Hospital Association by W. P. Morrill, M.D., chairman.

generally used is sodium carbonate, though some hospitals recommend trisodium phosphate as a "break down" although its value is questioned and has not been demonstrated in laboratory tests, as one pound of soda ash is equivalent to four pounds of trisodium phosphate. Economy would suggest that it be not used until proved of value. There are, however, other reasons for the use of alkali. The presence of soda decreases the tendency to the formation of calcium soaps. Certain dirts on soiled linen contain acids which the alkali will neutralize and some greases contain free fatty acids which the alkali will convert into soap thus aiding the detergent process.

BLEACHES. Bleaching is either a process of oxidation or reduction. The almost universally used sodium hypochlorite or javelle water is undoubtedly the best and in hospital work is particularly useful on account of its bactericidal action, it being best described as an impure Dakin's solution, and the identical material with which Semmelweis eighty years ago laid the foundation of hand disinfection in obstetrics, reduced his death rate from puerperal fever by ninety per cent, won for himself a lunatic's cell, and for motherhood practical immunity from the scourge which in his day condemned every tenth mother. It is not necessary to use bleach on hospital linen in every laundering and when it is used it should be rather light, not over two quarts of javelle water to a standard washer with six inches of water in the wheel.

SOUR. There are two reasons for the use of a "sour" in the laundry process. First to neutralize the alkaline materials remaining from the preceding process and second to remove certain stains which respond to acid but not to alkali. The most satisfactory sour is acetic acid used in the proportion of three to five ounces to a standard washer with six inches of water. If there are iron stains in the fabrics the addition of oxalic acid in the following manner is recommended: dissolve one pound of oxalic acid crystals in one gallon of hot water; use equal parts of the oxalic acid solution and of fifty-six per cent acetic acid, two to two and one-half ounces of each to a standard washer load.

BLUING. Bluing is used to cover up the grays, a process which with softer water and more carefully controlled processes is gradually becoming less and less necessary. Blue are of two types, the insoluble which are simply an exceedingly fine insoluble powder like ultramarine or cobalt blue and act by simple deposition on the surface of the thread; and the more common soluble or aniline blues which are actually absorbed by the fabric. The aniline blues have from four to thirty-six times the bluing power of the insoluble blues and have the added advantage of being more easily adjusted to the required tint.

STARCH. There are two types of starch process in general use, the one known as the cold starch process being in rapidly growing favor by reason of the fact that it eliminates the starch cooker and also one extraction process. A satisfactory grade of corn starch for the purpose will be supplied by any reputable supply house. Specially prepared starches cost more, but results do not justify their use.

Standard Washing Processes

When the soiled linen is received in the laundry it should first be sorted according to the character of the fabric, size of pieces and character of soiling. The following list gives a fair idea of classification: bed linen, dining room linen, operating room linen, uniforms white, uniforms colored, shirts and waists, collars and cuffs, socks and stockings, underclothing, overalls, colored aprons. All blood-stained linen should be given a preliminary soak in luke-warm water not over 100 degrees, after which it may take the course of all white work.

The standard washing process is as follows:

(1) Five minutes, lukewarm, three inches of water in cylinder after goods are saturated.
(2) Fifteen minutes hot suds, three inches water, sufficient soap to make six inches of suds on top of water. If powdered soap is used add one part soda to the three parts dry soap if water is fairly soft, increase soda according to hardness of water.
(3) Repeat (2).
(4) Five minutes hot rinse, six inches of water.
(5) Repeat (4) adding two quarts javelle water.
(6) Five minutes hot rinse, six inches of water.
(7) Repeat (6).
(8) Warm water, six inches, add four ounces sour and run ten minutes. Blue 10 minutes.
(9) Cold water to cool goods five minutes. If cold starch process is used the starch may be added directly to this load and run at least five minutes after addition of starch.
(10) Extract.

In loading extractor care must be used that articles are not entangled, as entangling leads to tearing of goods. Also extractor must be evenly loaded so that as it runs there will be no vibration. Neglect of this precaution is not only injurious to the machinery but dangerous to the operator. Safety covers should always be used.

If water of good quality is used it is not always necessary to use bluing.

All flat work can be taken direct from extractor to flat work ironer and the same applies to such work as is ironed on the press.

Articles that require hand ironing, however, must be partly dried first. This may be done in the open air, in which case they will require dampening. However, if a small tumbler is available, they may be tumbled partly dry and can then be taken directly to the ironing boards.

A BUSINESS PROPOSITION

The average individual is little concerned with his own health until sickness overtakes him. It is then that he is apt to compare his feelings with those of previous days when his attention was not particularly attracted to his physical being. Sickness is the manifestation of poor functioning organs just as much so as the "knock" of a motor engine is a warning of an ill functioning cylinder. If it is not remedied more trouble will follow. This is also true with the human body, if proper treatment is not instituted. It is further true that a great deal of sickness is preventable, if proper precautions are taken, but a large number of individuals will not heed nature's warning and will put such thoughts out of their minds, only trusting that sooner or later they will "automatically" become normal and healthy. Now wouldn't it seem foolish to pursue the same policy with reference to an automobile? Suppose that the knock in the engine should be treated with the same amount of complacency, about how long would the engine last? Is it fair that more serious consideration is not given the human body? It needs attention just as the automobile or any other mechanical device, and needs it more urgently at times. When an automobile becomes useless another one can be purchased, but when the body becomes useless it cannot be replaced. Happiness depends on health. One may have riches, title, fame, influence or any other asset, but if he does not possess that one essential requisite, health, his liabilities will far exceed his assets. Quite a few people who have good health really do not appreciate it, nor do they make any particular effort to retain their greatest of all assets. If they retain it, it is more by good fortune, not by good management.

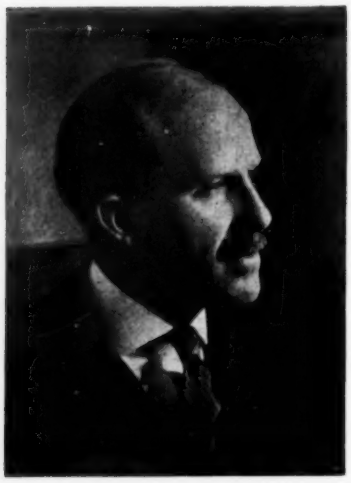
Two well-known Boston hospital superintendents, Dr. Washburn of Massachusetts General (left) and Dr. Howland of Peter Bent Brigham.

REPORT OF COMMITTEE ON GENERAL FURNISHINGS AND SUPPLIES*

TO MEET the demand for a hospital bed of rigid construction, firmly locked and capable of withstanding hard usage, with casters movable and sufficiently large to allow ready transportation of the bed from one part of the ward to another when desired, several satisfactory beds have gradually been constructed. These are now supplied with adjustable springs, modifications of and improvements on the gatch type of frame. Of these some are controlled by hand, others are adjusted by cranks or ratchets.

The tendency to finish the metal bed frames in various colors to correspond with the general color scheme of the room has been a gradual development.

The construction of private wards and rooms for private patients has created a demand for special room equipment, which is now being supplied by complete equipment in metal, including beds, cabinets, dressers, tables, wardrobes and other pieces. Monel metal has also become a close competitor with other metals in the construction of table tops.



Dr. Harold W. Hersey, chairman of the committee on furnishings and supplies.

Many superintendents have furnished their private rooms, at least in part, with wooden furniture, and it might be of interest another year if an effect was made to secure a few exhibits of high grade wooden furniture.

The average hospital mattress is subjected to unusual wear, and should be of hygienic construction, covered with durable material and capable of being sterilized. The comfort of the patient should also be considered. In the selection of the mattress, as in the selection of all other equipment, the better the grade purchased the longer it may be expected to serve. It is now generally conceded that curled South American horsehair comes the nearest to fulfilling the above requirements. On the other hand, very satisfactory reports have come from the users of other materials.

Pillows should be purchased with the same care as other supplies. Goose feathers are generally conceded to make the best pillows, and these should be covered with high grade ticking.

Until recently there have been but a few high grade casters on the market. In the selection of a caster several points should be considered. The wheel should be ample to permit free movement and the shank should be sufficiently strong to withstand the stress and strain to which it is subjected and to uphold the weight applied to it. The bearing should be ample to allow the caster to swivel readily. Rubber tires if used are very satisfactory when constructed in one piece, and ease of replacement is desirable. Several such casters are now on the market.

Supplies Should Be Standardized

The purchase of hospital sheetings, pillow cases, toweling, blankets, etc., requires careful study. Several of the exhibitors have urged the hospitals to make greater effort to standardize their supplies, in order that in requesting competing firms to submit bids, all may be judged on an equal basis.

Frequently a piece of cotton goods of apparently strong texture will be found to contain a filler. This may usually be detected by rubbing a piece of the cloth between the hands, when the filler will dust out leaving a much inferior surface.

It is well to adopt a uniform size in pillow cases, sheets and towels. Not only is this essential in order to obtain uniform bids from dealers, but also that the same sizes may be encountered throughout the institution. It is obvious that if a certain size is ample at one time the purchase of a larger size should be avoided.

Standardization of all equipment and supplies should be carried to the greatest practical degree. This may be accomplished by a careful study of the needs of the institution and the selection of the best articles to fill that need. The construction of special equipment entails additional expense, and delay in delivery. If on the other hand definite standards are established, the manufacturers can turn out a smaller variety of goods, the dealer may reduce the amount of his stock and the cost to the consumer is correspondingly lower.

It seems quite possible that the American Hospital Association will eventually believe it incumbent upon it to standardize many of the articles in hospital use.

*Prepared by Harold W. Hersey, M.D., chairman; Karl H. Van Norman, M.D.; L. H. Burlingham, M.D., committee on general furnishings and supplies.

CHILD HEALTH RAILROAD INTERESTS CONVENTION DELEGATES

A Trip to Healthland on the Child Health Railroad, an exhibit planned by the Atlantic County Committee of the New Jersey Tuberculosis League, was among the cleverest of the non-commercial exhibits. The trip on the Healthland Flyer was arranged through the Child Health Organization of America and seemed to attract with childish fascination staid hospital superintendents and other adults.

A miniature railroad, with dining and sleeping car accommodations, led up to Healthland. Daily service consisted of four trains: the Red Cheek Local, the Healthland Flyer, the Supper Express and the Shooting Star Limited.

Some points of interest on the road to Healthland were: Hot Soup Springs, Spinach Green, Baked Potato Hills, Play Meadows, Long Sleep Mountain, Orange Valley, East Toothbrush, Bathtubville, Bread and Butter Square, Egg Junction and Cocoa Crossing. From the car windows could be seen the products of the respective villages.

The exhibit was mounted on a large table and occupied the New Jersey Tuberculosis League booth.

It was in making education not only common to all, but in some sense compulsory on all, that the destiny of the free republic of America was practically settled.—Lowell.

EXPOSITION PROVES SURPASSING SUCCESS

THE exposition of equipment and supplies not only proved to be the outstanding feature of the twenty-fourth annual conference of the American Hospital Association, but excelled all similar exhibits of the past. Not only in point of number and extent of individual exhibits, but because of unusually favorable conditions and the keen interest on the part of convention visitors, this year's commercial exhibit resulted in greater returns to the exhibitor and in increased benefit to the convention visitors.

It would be difficult to point out any single contributing influence which resulted in the success of this year's exhibit. Young's Million Dollar Pier proved an ideal place for such a display; with windows on every side, with large roomy booths and spacious aisles, the exhibitor found opportunity to display his merchandise to the best advantage. The natural result was more complete exhibits of merchandise with greater attention paid to the comfort of the convention visitor.

Exhibits Draw Largest Crowds Ever

Whether it was due to the energizing value of fresh sea air or the fact that ample time had been provided for the study of the exposition, visiting hospital superintendents spent far more time in the various exhibits than hitherto and manifested a keen and constant interest in the various products throughout the entire session. While during some unusually interesting general session the booths seemed deserted, the general rule was to find a generous attendance scattered about the various spaces at all times of day and evening.

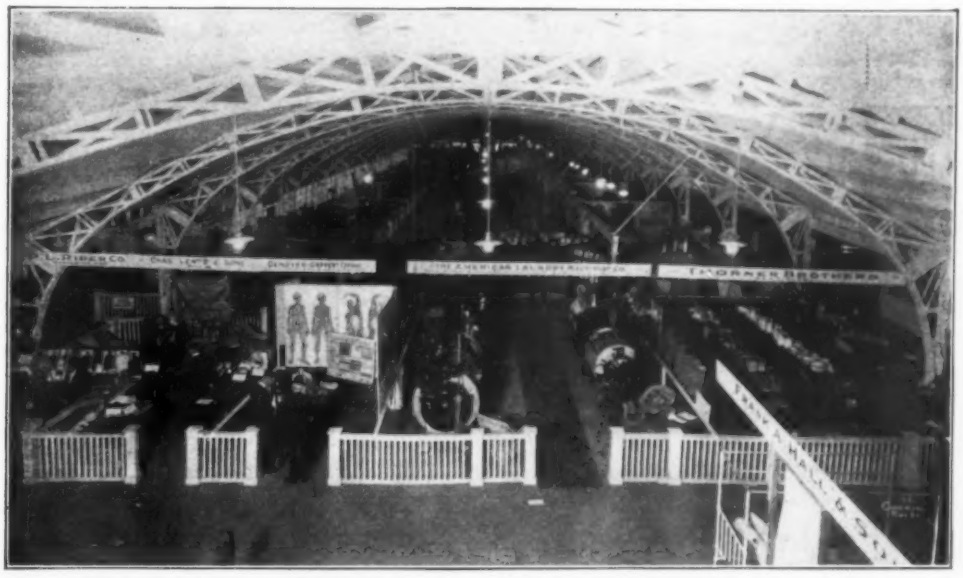
Credit must be given to those responsible for the planning of the 1922 exposition for the highly creditable display, and its success proves the soundness of the committee plan of organization and the systematic grouping of the various exhibits.

While interest attached to the reports of each of the five chairmen, the work of three of the special exposition committees was so comprehensive as to focus the interest of delegates during the entire session. The headquarters of these committees were thronged almost constantly with convention visitors interested in learning more of the subjects in which these committees specialized, to study the educational exhibit prepared by one of the committees or to secure the literature and bibliographies distributed by two of the other committees.

Committee Reports Suffer Delay

Through an unfortunate combination of circumstances, the reports of three of the exposition committees which were scheduled to be given at the general session of Tuesday morning, were not presented to the conference until nearly the end of the sessions Because of this fact much of the value of these reports in connection with the exposition was lost. It is safe to say that if these reports had been given according to the announced program even greater interest in the exhibits would have been evidenced by convention visitors. As it was, many delegates were unable to benefit from the special studies of these three committees to the extent that otherwise would have been possible.

One of the criticisms directed at the 1921 conference was an apparent lack of balance as regards the variety of products exhibited. The 1922 exposition marked a distinct improvement in this regard. Yet despite the wide variety of merchandise and products shown great improvement is still possible, and the further broadening of the commercial exhibits should be one of the aims of those in charge of future expositions.



In Exposition Hall on Young's Million Dollar Pier was held the greatest exhibit of hospital equipment and supplies on record.

The section devoted to building—construction, equipment and maintenance—presented only a limited range of products. When one considers the enormous variety of materials and equipment required in the construction and general equipment of a hospital the possibilities of this section of the exposition are obvious. It is likewise true that there is an ever increasing interest in building specialties, materials and building equipment on the part of the progressive superintendent. While the Atlantic City exhibit was perhaps more comprehensive than last year, the products shown in this section could not be called rep-

resentative. The lack of variety of products naturally handicapped the committee in charge of this section. Heating and ventilating equipment, lighting fixtures, doors, waste disposal devices, elevators and dumbwaiters are some of the lines in which superintendents are interested, but which were not shown.

Furnishings Exhibit Incomplete

General furnishings and supplies offered a fairly representative exhibit, as was the case last year. However, wood furniture was again conspicuously absent and no manufacturer or dealer presented a display of such furniture, although this item represents a considerable total in hospital equipment. Likewise there is an absence of specialized information applying to the purchase of such products. Rugs, draperies and miscellaneous housekeeping supplies also were lacking. Office furniture and filing devices are subjects of constant interest and in these too the exposition lacked. There was no exhibit of shelving, storage cabinets and wardrobes for use in the housekeeping and storeroom departments of the hospital, a branch of equipment in which there is increasing interest.

The exhibit of clinical and scientific equipment and supplies predominated in the exposition, as is perhaps to be expected. Displays this year, however, were unusually complete and a wider variety of products was shown. A specialized exhibit of laboratory equipment and supplies was lacking, despite the fact that laboratory equipment is one of the paramount questions of the day. Outside of this fact, however, very little criticism can be directed to this section of the exposition and the exhibits were unusually comprehensive, complete and attractive.

In some respects the exhibits devoted to foods and equipment for food service were disappointing. This does not apply to the individual exhibits, which were splendidly conceived, but rather to products which were not exhibited. There was but a single exhibit of general kitchen equipment and yet this is one of the most important divisions of hospital operation. Likewise there was no exhibit of chinaware and but a limited display of silverware. Specialized equipment, such as mixing machines, dishwashing installations and hot food service carriages, was well represented and the interest manifested in these exhibits emphasizes the desire on the part of hospital superintendents for more comprehensive displays of food service equipment.

Model Laundry Is Operated

The display of laundry equipment and supplies was superior to previous years. A complete laundry installation, in operation, was on display and the many hospital executives interested in this branch of their institution were able to gain considerable practical knowledge. A more complete exhibit undoubtedly would have been secured had it not been for conflicting convention dates preventing a number of prospective exhibitors from the hospital exposition. Water softening equipment and comprehensive marking and sorting systems were subjects that would have added interest to this section.

Looking down one of the long avenues of exhibits in Exposition Hall.

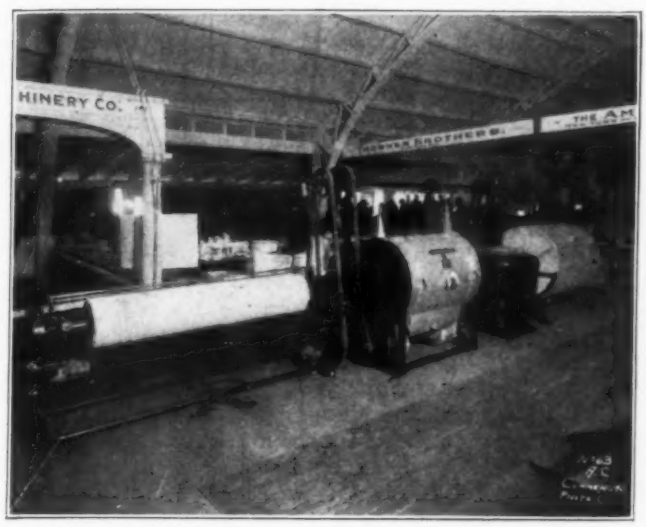
These general criticisms, however, should not be taken as detracting from the 1922 exposition. The variety and value of the exhibits this year were so far greater than previous years that suggestions for further improvement seem hardly necessary. Exhibitors and visitors were alike pleased with the results. Arrangement of the conference programs gave hospital executives ample time for a detailed and careful study of every exhibit and the thronged booths and the pleased expressions of exhibitors gave constant evidence of the satisfaction of all concerned.

Innovations On Display

The value of the exposition as a means for the introduction of new designs and devices is becoming more apparent each year. Among the innovations exhibited for the first time at the Atlantic City expositions were several types of adjustable beds, an invalid lifter, an attachment to a water sterilizer for the preparation of saline solution, a new egg boiler, a new electrically heated hot dressing carriage, several types of stretchers, an electric heater for use in connection with laundry marking and a number of other interesting devices. The keen interest of hospital superintendents in improvements in institutional equipment was evidenced by the number visiting various booths to inspect and study the latest innovations. Suggestions and criticisms received at these annual expositions are of undoubted value to the producer in perfecting new devices.

A notable feature of this year's exhibit was the effort

on the part of nearly every exhibitor to add to the comfort of his visitors. Nearly every booth contained chairs and settees permitting the comfortable study of products and opportunity for helpful conference. In fact several



A complete laundry installation was in actual operation at the exposition.

commercial spaces were used solely as reception and rest rooms.

While the majority of exhibitors came to the exposition with little thought of immediate sales, yet results in that direction were most gratifying. Many of the firms announced that the actual business booked during the convention totaled larger than at any previous convention.

Naturally there always are some complaints on the part of exhibitors. This is to be expected, to a certain degree, because of lack of proper facilities and natural congestion. The charges for furniture rental, inadequate (or exorbitant) janitor service and insufficient lighting in some spaces were the principal sources of annoyance this year. Unfortunately some of the causes of complaint were due to faulty planning and it is hoped that arrangements in future years will overcome such objections.

HOW FUTURE EXPOSITIONS CAN BE IMPROVED

The 1922 exposition plainly demonstrated the fact that the American Hospital Association has outgrown hotel conventions; that given proper planning and facilities an exposition of sufficient size can be developed to warrant the use of suitable public auditoriums as was done this year.

The interest manifested in the work of three special exposition committees which did the more intensive work offers complete justification for this plan of exposition development as tried this year.

It would seem logical, that in planning the 1923 exposition a similar form of committee organization be followed, dividing the exhibits in the same five general groups that were employed this year. A further step can well be taken by the inclusion of commercial representatives in the make-up of these five special committees, thus securing for the association more active cooperation of exhibitors in the planning and conduct of the exposition. For instance, instead of having five committees consisting solely of hospital superintendents, a general exposition committee might well be formed that would consist of the executive secretary of the association, a hospital superintendent as chairman of each of the five divisions and likewise a representative of commercial interest for each of the five general groups. This would result in a general exposition committee of eleven members, on whom would devolve the responsibility of the general planning of the exposition, the securing of proper facilities for visitors and exhibitors alike and the establishment of general rules of conduct to apply to the exposition.

With such an organization appointed within the next sixty days, plans could well be laid for making the 1923 exposition of even greater value than this year. The inclusion of commercial representatives would bring to the association the expert knowledge and experience of these men and insure a degree of cooperation on the part of exhibitors that would be of outstanding benefit. Likewise for the exhibitors such a plan should insure relief from petty annoyances and lack of proper facilities that so frequently mar the conduct of an exposition of this kind.

HOSPITAL EXHIBITORS ORGANIZE

Believing that the active cooperation of interested commercial firms would be of great assistance in the conduct of future hospital expositions, a permanent organization was formed at Atlantic City which is known as the Hospital Exhibitors Association. The express purpose of this association is to cooperate with the executives of the American Hospital Association so as to develop future expositions that will be of greater educational value to hospitals and allied institutions.

An executive committee was appointed to confer and act with the American Hospital Association in the development of the 1923 exposition. This committee consists of B. A. Watson, Crescent Washing Machine Company, chairman; Edward Johnson, Meinecke & Company, secretary; J. E. Hall, American Sterilizer Co.; L. C. Walker, Baker Linen Co.; Paul Esselborn, Century Machine Company; Henry L. Kaufman, Henry L. Kaufman Company; J. M. Myers, MacMillan Company.

The practical experience and progressive ideas of these representatives of well known commercial firms should be of great value to the American Hospital Association in the general planning and detailed arrangements of future expositions. The new association is direct evidence of the desire of mercantile firms dealing with hospitals to assist to their utmost in developing the educational possibilities of the annual exhibit.

Dr. Anker of St. Paul, president of the association at its former convention in Atlantic City, and his friend, Dr. Olson of Englewood Hospital, Chicago.

NEW YORK AND PHILADELPHIA HAVE OPEN HOUSE

FOLLOWING the close of the convention Thursday afternoon a number of the delegates entrained for New York and Philadelphia where they spent Friday and Saturday visiting hospitals and witnessing various demonstrations.

The hospitals in New York which were open or inspection included the following:

Bellevue, Woman's, Mount Sinai, Fifth Avenue, St. Vincent's St. Luke's, Beth Israel, Brooklyn, Long Island College, King's County, Metropolitan, City, Harlem, Fordham, Gouverneur, Sea View, Willard Parker and Kingston Avenue.

A few of the delegates took advantage of a boat trip around Manhattan Island, starting from the foot of East 22nd Street at 10:30 a. m. The boat stopped at Welfare Island which gave opportunity for a brief visit to the workhouse and penitentiary, and at Ricker's Island where the New York Hospital for the Care and Treatment of Drug Addicts was visited. At Hart's Island they visited the branch penitentiary and trade schools. Here luncheon was served, after which the trip around the Island was completed. In the afternoon there was a special excursion to Welfare Island where members of the social service department of Metropolitan Hospital escorted delegates on visits to the New York City Hospital, the Metropolitan Hospital and the Central Urological Hospital. At 4 p. m. tea was served in the nurses' home of the Metropolitan Hospital, after which delegates returned to the Women's City Club.

Those who visited the Woman's Hospital in the State of New York had an opportunity to inspect the telegraphone. After each operation the surgeon dictates his description into this instrument which transmits the dictation to a special stenographer's room.

A number of the delegates were especially interested in the new Fifth Avenue Hospital, with its single room service. Three floors of this hospital are now in active service and the institution was formally open on Thursday, September 28. Many also visited the new buildings at Mount Sinai Hospital, including the private pavilion, children's hospital and the auditorium.

St. Luke's Hospital was especially interested in showing its very complete x-ray department and its children's cardiac clinic. At the hospitals of the department of health there was opportunity to study the construction, arrangement and management of hospitals for the care and treatment of contagious diseases.

Thirteen Philadelphia hospitals were scheduled for inspection, and although not many delegates accepted the hospitality of the Hospital Association of Philadelphia those who looked in upon some of the hospitals of that city found themselves amply rewarded for their visit.

Some features which caught the attention of superintendents at the various Philadelphia institutions were:

The recordkeeping system, laboratories, x-ray department and large out-patient department at Episcopal Hospital, an institution of 520 beds.

A private pavilion, new nurses' home and small maternity building at Germantown Dispensary and Hospital, of interest to persons contemplating the construction of separate hospital buildings.

Hahnemann Hospital's social service department and its system of food service for private patients.

The food service from the private floor diet kitchen and the storeroom system at Jefferson hospital.

Plans for a $15,000 nurses' dining room at Jewish Hospital.

Lankenau Hospital's elaborately functioning follow-up system, and its effective way of manufacturing soap from waste fats by cold process methods.

The cafeteria service for nurses, a new five-story building in process of construction, and the circular wards at Methodist Episcopal Hospital.

Modern construction at Misericorida Hospital, an institution of 300 beds with several new buildings.

The extensive rebuilding program at Philadelphia General Hospital with its accommodations for 2,000 patients. Interest was displayed in the radium emanation rooms and work shops, the new nurses' home and various well developed out-patient clinics.

Reclamation of gauze at Pennsylvania Hospital; also its complete social service department.

Special demonstration clinics at Presbyterian Hospital on Friday afternoon and evening; among them a cardiac clinic, a prenatal clinic, and a children's clinic. Also new dietetic and bacteriological laboratories.

St. Agnes Hospital's new nurses' home and recently remodeled dispensaries, x-ray laboratories and operating rooms.

The complete and up-to-the-minute surgical pavilion at the University of Pennsylvania Hospital.

"Nursing is an art which concerns every family in the world."—Florence Nightingale.

(Underwood & Underwood)

New York's skyline and water front.

AMERICAN ASSOCIATION OF HOSPITAL WORKERS HOLDS PROFITABLE MEETING

THE semi-annual meeting of the American Association of Hospital Social Workers held September 26-28 was well attended. At the opening session the program included two main topics—community responsibilities of the hospital and social elements in medical training.

Miss Frances Stern, food clinician at the Boston Dispensary, was the principal speaker on the first topic. She discussed the part played by the hospital in fitting citizens for home and industrial life, especially by teaching them how to live in such a way as to maintain and improve health. One of the most important elements in social as well as in physical life is food, and Miss Stern illustrated her talk by specific reference to the food clinic. She showed how the clinic meets the needs of individual patients and what it means to the community to have such a resource. The usual food distributing agencies are far from meeting the need for diet and dietary teaching adapted to the condition of individual patients. Such feeding and teaching can be correctly done only in connection with medical diagnosis and supervision.

Around the booth of the Service Bureau on Hospital Social Work, in charge of Miss Ida M. Cannon and Miss Lena R. Waters, there was ever a crowd. All hospital social workers in attendance registered at the booth and informal lectures were held there. An important ant part of this exhibit was its psychiatric section.

Mr. Frank E. Wing, director of the Boston Dispensary, in discussion brought out other aspects of the social responsibilities and relationships of the hospital and dispensary.

Miss Dorothy Ketcham, director of social work at the Hospital of the University of Michigan, was unable to be present in person, but sent a paper in which she summarized the results of a study of the teaching now being done in departments of social work. Of 300 departments only six are known to be contributing in a definite manner to the education of medical students. About fifteen are assisting in the training of nurses, by lecture courses, by practical work, or by a combination of the two. Miss Ketcham quoted a number of interesting opinions from hospital social workers and discussed the value of the contribution which might be made by hospital social workers to the social education of the physician.

Miss Ida M. Cannon emphasized the point that such contribution need not necessarily be in the form of actual teaching but that progress in the definition of medical social work might be even more important and that the medical profession would in time make use of any really valuable body of knowledge which might come from the practice and interpretation of social work.

The business meeting of the association was held on September 27 at the Chalfonte Hotel. The treasurer's report showed a small balance to date and a prospect of getting through the year on a narrow margin. Nevertheless the contributions from districts are putting the association on a surer financial basis than it has had heretofore.

The president reported the action of the executive committee in accepting the constitution and by-laws of the psychiatric section and those of the Minnesota district. A new department of social work is in process of formation in Queen's Hospital, Honolulu. This association has been consulted as to its plans, and has been interested in this extension of the work.

Plans for the association's work in the coming year were discussed. They include the carrying out of committee work and programs in all the districts, publishing of pamphlets by the association (these in response to many requests for special literature), appointment of programs and nominating committees one year in advance of annual and semi-annual meetings, and work by committees of the association in recruiting of students, preparation of an exhibit and other work connected with publicity and education.

At an informal conference of superintendents of small hospitals under the auspices of the service bureaus on hospital social work, it was voted to ask the American Association of Hospital Social Workers to appoint a committee to study, during the coming year, the problems and methods of social service in small hospitals and to report at the meeting of the American Hospital Association next year.

HOSPITAL LIBRARY AND SERVICE BUREAU EXHIBIT RECEIVES MANY CALLS

More than 2,500 inquiries for bibliographies and approximately 300 requests for package libraries were made at the booth of the Hospital Library and Service Bureau during the convention.

Three librarians were in constant conference throughout the day and evening, and every conceivable question relating to hospitals was put to them. Many superintendents, architects and other hospital workers visited the booth each day and some several times daily to look at the charts, floor plans of institutions and other informative material.

The exhibit of hospital plans presented by the library is the largest collection of these plans ever made, it is said. Blue prints of hospitals, sanatoriums, nurses' homes and allied institutions of all sizes and localities were represented. Accompanying this exhibit was the library's list of hospital architects.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION HAS ENTHUSIASTIC ANNUAL SESSION

THE sixth annual meeting of the American Occupational Therapy Association marked an important milestone both in the growth of the organization and in its affiliation with the American Hospital Association.

The first session opened Monday, September 25, at 2:30. Owing to illness Dr. Herbert J. Hall, president of the association, was unable to be present. In his absence Mrs. Carl Henry Davis, member of the board of management, called the meeting to order and requested Mr. T. B. Kidner to take the chair.

The Rev. William W. Blatchford gave the invocation and the deputy mayor, Mr. Nichols, the address of welcome. Mrs. Eleanor Clarke Slagle read the president's address, which Dr. Hall had sent to her.

In his presidential address Dr. Hall first called attention to some of the things which the association has done and which can be accomplished even more effectively in the future "if it continues to be an advisory body and not a dictatorial one, if it takes care to be widely representative, if it avoids sectional jealousies and cooperates perfectly with the state and other groups of workers."

"Our meetings have been criticized," he declared, "because we have had too many papers read and because not enough time has been allotted to individual and local society reports. It is from such reports that we can expect real enlightenment. Of the excellent addresses that have been given in the past it may be said that they have been, for the most part, too general in their scope, that from now on we should try to make our formal papers cover special phases of our work. The exhibitions of crafts work have shown variety and originality, yet they have been rather too much alike."

T. B. Kidner, new president of the American Occupational Therapy Association.

Dr. Hall commented upon the remarkable vitality of many of the local societies and said they should be encouraged in their independence, but the local societies should bring their achievements to the national organization for appraisal if they do not wish to become limited and provincial. He recommended some constitutional changes, among them the substitution of an augmented board of managers for the House of Delegates. This recommendation was carried out later in the convention.

Dr. Dunton thought a committee should be appointed to draft resolutions of sympathy for Dr. Hall in his illness and of thanks for his delightful address.

Mr. Louis J. Haas, director of occupations, Bloomingdale Hospital, White Plains, N. Y., read an excellent paper on observation of patients' reactions as the guide to further treatment.

Mr. Haas said: "When the new case has been introduced to the proper task, the carefully planned and controlled machinery of therapeutic occupations does not run smoothly. Experience shows the problem is not so simple as this. The planning of the treatment has only begun and must continue through the patient's stay in the hospital. Those applying various forms of occupational treatment must observe and record the patient's progress expressed in reactions. The records are read, carefully weighing the information contained. This guides and furthers treatment.

"Therefore it is essential that there exist some definite method of receiving and recording information concerning the new case of observing the patient's reaction to the treatment. All of this information is thus available to guide those who plan and present occupational treatment."

Mr. Haas stressed the value of record keeping, showing the method of receiving information, how recorded, records kept of observations and progress; instructor's weekly report, and the work-accomplished record.

Many factors are to be considered in planning treatment, he declared, such as examples of treatment adaptation as applied to the underactive case; the overactive case, changes in treatment to meet relapse, when no added precautions are required and when conditions demand precautions; changes to meet various degrees of coordination; and re-training for those who lack self-reliance.

Experiences in directing an occupational therapy association were related by Miss Idelle Kidder former director of the Missouri Occupational Therapy Association. The first work of this association was the organization of a committee composed of deans of schools of medicine, officers of the Council of National Defense, and representatives of a school of mechanical trades, an institute of fine arts, a junior league workshop, a group of specialists and a secretary. With this executive committee, the school was soon founded, the financing being done by the Junior League of National Defense. The school was at once placed upon a high plane. Some of the graduates were employed in a hospital at St. Louis and elsewhere. In order to understand mental cases, arrangements were made for pupils to have a probationary training in the Kankakee State Hospital. This is working satisfactorily.

Miss Kidder concluded that the chief points which have brought about success were the wisdom shown in: (1)

The plan for thorough and extensive work and adherence to it; (2) the effort to have a first-class school; (3) the fact that there was one organization equipped to standardize plans and furnish guidance to all institutions within a state where conditions and problems are more or less identical; (4) general publicity through the press; (5) the acceptance or recommendation for work of no untrained volunteers; (6) personal visits to institutions to learn what had been accomplished and offers to carry out plans in close cooperation.

This session was concluded by a paper from Dr. Frederic Brush, medical director of the Burke Foundation, White Plains, N. Y.

Should Not Resume Work too Soon

Dr. Brush based his report on the convalescent treatment of nearly 20,000 men and boys in a country institution for a period of seven years. His patients were at all times from moderately defective to persons of high ability. Almost every ailment in some form or condition was represented. Dr. Brush used occupational therapy in the broad sense of including play and recreation in work about the grounds and institution. He valued especially activity out of doors. As the strength of the patients returned they were graded up to a period of from three to five hours' occupation. From this they passed frequently into a full day's employment about the institution while still under surgical dressing or other convalescent care. The final phase in his plan was return to old or better adapted wages, work or environment.

He suggested three age groupings, those under 15, from 15 to 50, and from 50 on. Those under 15 years gain in close contact with their elders and in group work. The middle age group adapts itself to leadership. As they press forward two difficulties appear: To restrain them safely in the earlier stages, and then to hold them long enough in gradual upbuilding. Most men want to go back to the job and social strain too soon. The older group are best adapted to policeing, gardening, care of the grounds and routine shop work.

Sales of the men's occupational products amount to not more than $1,000 per year, which shows how this work cure is given mainly to keep the patient in tone and spirit as well as in good physical condition. The real question is what most of the men make and do in after life because of this extra training.

Dr. Brush said that he was inclining to fewer crafts and shops and more to general upkeep and outdoor construction work, with few supervisors and more patient leadership.

Office Work Is on Increase

On Tuesday morning a business meeting was held of which the most interesting feature probably was a report of the secretary-treasurer, which could be divided into office work and field work. The former included replies to many inquiries regarding the inauguration or developments of occupational therapy in hospitals, advice on building equipment and material and on the engagement of personnel. The proof that occupational therapy is not very widely known was shown in numerous inquiries as to its nature and scope. It is of interest to know that it is planned to use this therapy measure at the New Haven Hospital where Yale medical students will receive their training. A conference was held with Dr. McQueek, who is preparing a thesis for his degree at the Oxford University, on occupational therapy of dementia praecox cases. Dr. Askano of Japan, the industrial rehabilitation officer of an important manufacturing organization in Tokyo, also sought advice upon what he termed the important first steps in rehabilitation. Officials of five states were advised regarding civil service requirements in their respective states.

On account of the increase in office work it has been necessary to engage office room in New York and to secure the part-time services of a clerk. On this account the expenses of the society must necessarily be heavier during the ensuing year and an increase in membership is desirable, the report brought out. Fifty so-called dead applications, that is, individuals who had not completed the necessary formalities, chiefly that of paying dues, which were made at the end of the last year, have been reduced to four. Eight members have resigned; one has died. The total membership now numbers slightly over 500.

The secretary-treasurer's work in the field consisted of visits to institutions and addresses to the public, to clubs and associations. At a meeting of the state board of control of Minnesota a whole day was given over to addresses by the secretary-treasurer and by Miss Bess Sutton, a member. Visits were paid the Veterans' Bureau Hospital at St. Paul, the state hospital at Rochester, Minn., and to the Mayo Clinic. In Milwaukee a number of meetings and conferences were held. A meeting of occupational therapy in Chicago was attended; also several hospitals were visited. An important conference was held at the national sanatorium, where Marion Shanklin is director. Another conference was held with the board of managers of the National Soldiers' Home at Dayton. At a meeting in Washington ways and means by which courses in social industries and rehabilitation might be developed generally were considered. A number of addresses were given at branches of general federation of women's clubs and the annual meeting was attended at Chautauqua. Here a number of associations sent helpful exhibits.

The report of the committee on finance was as follows:

"The question of financing the American Occupational Therapy Association during 1922 was left to the discretion of the board of management and the chairman of a finance committee. Inasmuch as the funds derived from the dues of members were sufficient for the needs of the current year, it was thought best not to institute a campaign for additional funds until business should improve.

"The report of the secretary-treasurer for 1922 makes it evident however that additional clerical help will be necessary if the business of the American Occupational Therapy Association is to be carried on without undue sacrifice by the board of management and officers and it is therefore cordially recommended that the association underwrite and support the very modest budget of $2,000 presented by the secretary-treasurer for 1923."

Mr. Kidner then made the report for the committee on research and efficiency, stating that but little work had been done by his committee, due largely to a trip abroad which he took in connection with work for the tuberculosis. He then proceeded to give some very interesting details of New York hospitals stating that we had but little to learn from the other side, where there is a great deal of good work going on in spots, especially in the several settlements for ex-service men.

Miss Ruth Wigglesworth then gave a report for the committee on teaching methods.

Dr. Dunton followed with a report on publicity and publications, giving some details on *Archives of Occupational Therapy* and analyzing the annual subscription list of which 38.8 per cent represents members of the society and other individuals; 20.5 per cent, mental or nervous

hospitals; 14 per cent, general hospitals; 13.5 per cent, libraries or universities. Attention was called to the rapidity with which the proceedings of the last meeting were published in comparison with those of former years.

Miss Susan C. Johnson read the report upon education in which she related that the gathering of data concerning salaries and hours upon which aides are employed and the existing conditions with regard to certificates, credentials, civil service requirements and other legislation which affects occupational therapy in the different states and the assembling of data which should set forth the true therapeutic value of occupation is progressing. The report was largely statistical, but included a number of reports of specific instances of recovery received from various hospitals as the result of her questionnaire.

House of Delegates Is Abolished

By a considerable majority it was voted to abolish the house of delegates and to increase the board of management to nine. At a later meeting the following were elected to the board of management:

Dr. B. W. Carr, Veterans Bureau, Washington, D. C.

Dr. Philip K. Brown, San Francisco, Cal.

Dr. James J. Mattison, Soldiers Home Management.

Dr. Frankwood E. Williams, National Committee for Mental Hygiene.

Miss Florence Fulton, of Philadelphia School of Occupational Therapy.

Miss Meta Rupp, of New York Society for Occupational Therapy.

Dr. Horatio Pollock, New York State Hospitals Commission.

On Tuesday afternoon Miss Winifred Brainerd of the Presbyterian Hospital, Chicago, opened an interesting discussion upon occupational therapy in general hospitals by her paper on the workshop in a general hospital. In this were considered the equipment, the crafts best adapted for use of those under instruction for a short period, and some of the advantages which had been observed to result from the use of the workshop. Here the patient usually feels that he is without restraint and by his contact with the aides he is ready to open up many channels of thought. He is inclined to air his pet grievances. He talks freely of the one whom he thinks has not been fair to him or complains that his tea was cold on a certain occasion. While these things are trivial, to the abnormal mind of the patient they loom up as mountains and culminate in a mental attitude which does not speed recovery. By telling them a patient gets relief and they do not bother him. In the workshop the patient is also given many opportunities to do little tasks which cannot be done upon the ward.

Miss Elsie Hassenstein of Cook County Hospital, Chicago, then described work upon the wards, its advantages and difficulties. She emphasized the importance of keeping up the interest of the physician in the patient's work so that he will act as a personal stimulant, and of making staff physicians responsible for the work of the patients.

A round table upon recreations followed; it was opened by a paper upon music as a means of mental discipline by Mr. van de Wall, musical director of the New York State Hospital Commission.

Mr. van de Wall's address was punctuated by many witty remarks which lent considerable emphasis to the points which he wished brought out. He quoted Dr. Soseman, who stated that any program of mental hygiene has to satisfy four demands: first, research for the descriptive element; second, the influence of these elements on the etiology of these diseases; third, the elimination of these influences; fourth, the power of resistance of the threatened individual. He stated that music as a means of enforcing mental discipline is a subject primarily concerned with the last item.

van de Wall Tells Benefits of Music

In conclusion he stated that music is, in the struggle for the restoration and maintenance of mental, individual and group discipline, of practical efficient help, and constitutes an essential factor in the therapeutic program of every sanatorium or hospital. He was followed by Miss E. M. Huseby, who asserted that the value of exercise as a remedial measure cannot be overestimated, but of primary importance is correct posture. Among mental cases there is a great deal of tension which may be overcome by utter relaxation.

Mrs. Eva Eskridge Harrington then read a paper upon games and dramatics, in which she first discussed the interesting question of the place of play in adult life. She detailed her work at Bloomingdale Hospital. In conclusion Mrs. Harrington said that in all recreational activities it is possible to get very close to the patient, but in order to do this it is necessary to play together as equals, not as a well person and a sick one.

On Wednesday morning reports of the occupational activity in the various states were given by individuals

Delegates to the American Occupational Therapy Association grouped on Young's Pier. In

who are actively concerned in directing such, this formed a most interesting feature, of which space permits mention only.

In the afternoon the very important question of the financial side of occupational therapy was taken up by Dr. Horatio W. Pollock, statistician of the New York State Hospitals Commission. He stated that there are two distinct aspects of the question of occupational therapy. First, as a department of medicine; second, as an industrial undertaking. From either of these standpoints it is worthy of support and funds should be provided for it. It, however, is necessary that its value be demonstrated clearly to the general public before adequate financial support will be granted. Proper facilities should be provided including a building to serve as a center. Some suitable activity should be provided for every class of patient. In many of our state hospitals, a revolving fund has been created by the generosity of private individuals, which is used for the purchase of supplies and which is augmented by the sale of the work of patients. Such is not adequate for large hospitals. He believed that aides should have no part in the financial management. Definite records of all work done should be kept.

Haas Gives Per Capita Costs

He was followed by Mr. Louis J. Haas, director of men's occupations at Bloomingdale Hospital, who gave financial details of the work and concluded with the statement that the per capita cost is about twenty cents per working day for men and about sixteen cents for women.

Dr. W. W. Richardson of the Mercer Sanatorium in his paper showed that the per capita cost per patient per month was about $4.50 or about 3½ per cent of the total cost of maintenance.

This was followed by a round table on training courses conducted by Miss Ruth Wigglesworth of the Boston School of Occupational Therapy. There was much discussion on this important subject, participated in by a considerable number.

On Thursday morning the first part of the session was devoted to reports of experiences in hospitals for ex-service men.

Miss Martha Emig opened the discussion upon general hospitals and was followed by Miss Dorothy Rouse. She in turn was followed by Miss Esther McComber who dealt chiefly upon the value which music had played in aiding convalescent men. Miss Willard stated that gardening was found to be the most valuable aid in her experiences.

Dr. Lloyd W. Ziegler opened the discussion upon neuro-psychiatric hospitals by a paper entitled "A Study in Occupational Therapy for Psycho-neurosis." This showed careful research upon the part of an author and is regarded as a distinct contribution to the literature of occupational therapy.

Miss Jeannette Moody then spoke of the craft work carried on under her direction at the Bronx Hospital.

Mr. C. C. Dunn of St. Elizabeth's Hospital emphasized the need of friendliness in contact with patients and regretted that there was not a better follow-up system in use.

Dr. B. W. Carr, chief of the physiotherapy and occupational therapy sub-section of the U. S. Veterans' Bureau read an excellent paper upon "Occupational Therapy in Tuberculosis Hospitals."

The remainder of the session was devoted to a round table on records, conducted by Dr. H. W. Pollock.

Mrs. Marshall Price of the Sheppard & Enoch Pratt Hospital described the records in use at that institution and was followed by Dr. Dunton of the same hospital who described the form used by him personally for the financial analysis of the costs of the occupational therapy department.

At the afternoon session a report of the activities in the National Soldiers' Homes was read by Miss Mary Shanklin, after which the reports from states were resumed.

T. B. Kidner Is New President

At the close of this session the new president, Mr. T. B. Kidner, was inducted into office. Mr. Kidner, an Englishman by birth, was for a long time a resident of Canada where he was connected with the Manitoba school system. Early in the war he entered the service of the Invalided Soldiers' Commission and continued this work for some time, eventually being loaned to the United States government when it entered the war. Since the war, he has been connected with the National Tuberculosis Association, as its institutional secretary. He is also one of the founders of the American Occupational Therapy Association.

As there was an urgent request on the part of many members that the sessions be hurried in order that there might be an opportunity to visit neighboring institutions, the round tables upon crafts best suited for the mental and nervous, and crafts best suited for the tuberculous, which had been scheduled to take place on Friday morn-

the background can be seen Hotel Tragmore and other buildings that border the Boardwalk.

Occupational therapists laid claim to the most attractive booth in Exposition Hall.

ing, were held Wednesday night. At both of these was considerable interest and discussion. The two round tables scheduled for Friday afternoon upon crafts best suited for bed cases and crafts best suited for the disabled were held on Thursday night. Here too, much interested was manifested.

The opinion of the majority was that this was one of the most successful meetings held by the association and it would appear that the short sessions, with the absence of the evening sessions, except in the two instances noted, were especially responsible for giving opportunity for personal contact. It was noteworthy that on the day following the first evening session members complained of greater fatigue.

Arrangements at the pier were most satisfactory except that in a few instances, notably when the meetings were held in the section hall, there were interruptions due to necessary household arrangements of the pier.

OCCUPATIONAL THERAPY EXHIBIT IS LARGEST EVER ASSEMBLED

Never has there been assembled so complete an exhibit of arts and crafts as was on display in the booths of the American Occupational Therapy Association.

Fifty-nine hospitals from various sections of the country contributed to the exhibit. Hospitals for the blind, hospitals for the crippled, tuberculosis sanatoriums, military institutions, mental hospitals and general hospitals had the handiwork of their patients on display.

Among the many arts and crafts represented were: weaving, basketry, carving, metal work, toy making, knitting, crocheting, furniture making, rug making (from rag to Navajo), printing, leather work, stenciling, copper work, etching, hand wrought silver work, jewelry making, pottery, lace making, batik work and many others.

Thousands of delegates and visitors on the Pier crowded the central booth, a spacious affair, and its adjacent overflow quarters at all times of day and evening. None of the objets d'art was for sale or the exhibit would soon have been carried away by purchasers, but orders were taken for duplicate articles and many persons left one or several.

In almost all cases the money taken in for articles sold goes to the individual patient, after the hospital has been reimbursed for the materials. A few of the institutions represented in the exhibit even provide the materials gratis. It is a practice common among a number of the hospitals to deduct from the sale price a charge of 10 per cent for waste, in addition to the cost of raw material.

Mrs. E. G. Shreve of Atlantic City was chairman of the committee on arrangements of the exhibit and with a staff of workers was kept constantly busy answering questions about the exhibit.

Several new crafts were being taught in the main booth and aides from many sections of the country gathered about to learn the latest.

In general attractiveness and appeal the occupational therapy exhibit easily dominated the entire exposition, both commercial and non-commercial displays.

A. H. A. RECOGNIZES MISSOURI AND PENNSYLVANIA ASSOCIATIONS

Recognition as a geographical section of the American Hospital Association was extended to the Missouri Hospital Association and the Hospital Association of Pennsylvania at the June meeting of the board of trustees of the national organization. Formal application of the Missouri association was signed by Dr. L. H. Burlingham as president. J. M. Smith, executive secretary, signed the application of the Hospital Association of Pennsylvania. The Pennsylvania Association was organized in December, 1921 and the Missouri association in February of this year.

PROTESTANT HOSPITAL WORKERS HOLD SECOND ANNUAL CONVENTION

CHURCH hospitals and problems peculiar thereto absorbed the attention of some seventy-five to 100 representatives of the Protestant Hospital Association in a three-day convention at Atlantic City terminating shortly before President George D. O'Hanlon called to order the twenty-fourth annual conference of the American Hospital Association. A program of addresses and round table exchanges constituted the second annual session of the Protestant organization. The smaller gathering with its opportunity for intimate and specialized discussion was regarded by delegates as of measureable benefit.

Dr. C. S. Woods Is New President

In the absence of President Pliny O. Clark, who it is understood has recently forsaken the hospital field, the convention was opened on Saturday afternoon, September 23, by Dr. C. S. Woods of Indianapolis, vice president. At the business session on Monday, Dr. Woods was unanimously elected president of the association for the coming year. The Rev. H. L. Fritschel of Milwaukee Hospital in Milwaukee, was named vice president with no dissenting votes, and the following members of the executive committee were chosen: for a three-year term, the Rev. James M. Long, Birmingham Baptist Hospital; James H. Mohorter, United Christian Missionary Society, St. Louis; and the Rev. C. O. Pederson, Norwegian Lutheran Hospital, Brooklyn; for a one-year period: the Rev. J. H. Bauernfeind, Evangelical Deaconess Hospital, Chicago.

Dr. C. S. Woods of Indianapolis will head the Protestant Hospital Association for the coming year.

To assist in obtaining an amendment or repeal of existing laws imposing taxes upon the legacies of hospitals, homes and other charitable organizations, the association took action by means of a resolution. The president will appoint a committee to cooperate with other committees and organizations to oppose such legislation. Another resolution adopted recommended the regulation by state and other legislative bodies of the sale and use of firearms, this from the angle of lessening the number of injury cases in hospitals.

Welcome to Atlantic City on behalf of its citizenry and clergy was extended to the delegates at the opening session by the Rev. H. More Blake, president of the Atlantic City Ministerial Union.

The secretary's report presented by Dr. Frank C. English showed a total membership in the association of approximately 200. The educational program of the past year has been among the ministers of the nation in an effort to quicken the sense of church people to the need of increased hospital facilities. A call has also been sent out through the churches for more student nurses.

In concluding his report, Dr. English declared: "It may be a little too early to announce that we are looking to a world program. Surely Christian America has responsibilities to the whole world. We need to train doctors and nurses with the spirit of sacrifice for our foreign hospitals, and we should not expect to escape the responsibility of providing healing for the afflicted throughout the world."

The church hospital from the triple viewpoints of its support, administration and vision formed a topic for three forceful papers at the first day's session; they were presented respectively by C. B. Hildreth, superintendent of St. Luke's Hospital, Cleveland; C. S. Pitcher, superintendent of Presbyterian Hospital, Philadelphia; and Dr. C. S. Woods of Indianapolis.

"A large proportion of both nurses and doctors are in the profession more because of the remuneration than the desire to administer to the needs and suffering of their fellow men," said Mr. Hildreth in his address. "Christian doctors should make up staffs of church hospitals and Christian nurses should compose the nursing groups." He urged the great need for additional hospital bed capacity. Dr. N. E. Davis of the Methodist Hospitals and Homes Association of Chicago led the discussion of the paper.

Issue with the report of the committee on training of hospital executives was taken by Mr. Pitcher in discussing the administrative aspects of a denominational hospital.

"The majority of students who have only the training outlined in this report," he asserted, "would be too young and inexperienced to grasp the situations with which they would have to cope in the administration of a hospital. Disciplinary training of the young, who have had no experience, is inadequate. I believe the old apprentice system, backed by experience, is preferable when supplemented by didactic instruction, through meetings of the hospital associations and special courses in universities and other suitable places. It is not within the scope of

human minds to accumulate the information a superintendent should possess through a short course of training. This can only be secured through years of experience in administrative work."

Mr. Pitcher also attacked the collateral inheritance tax imposed on charitable institutions. Discussion of his paper was led by Miss May A. Middleton of Philadelphia.

Some of the possibilities which lie in the path of the church hospitals were enumerated enthusiastically by Dr. C. S. Woods in an inspiring address on "The Vision of the Church Hospital."

From the standpoint of practical application, no single paper of the convention was of more value than the address on Saturday evening of Ralph Welles Keeler, director of publicity of the Methodist Hospitals and Homes Association, Chicago. Something of the mechanics of preparing copy for the press, of news values, of human interest material in the various hospital departments, and of the vitalizing of statistics and annual reports was contained in his address.

The Rev. Herman L. Fritschel concluded the first day's session with a well prepared paper on "The Relation of the Church to the Hospital."

Special Services Mark Sunday

On Sunday morning the Atlantic City churches, most of which are convenient to the hotels bordering the Boardwalk, opened their doors to the delegates. In many cases special sermons were delivered, stressing the value of denominational and interdenominational hospitals.

The Rev. N. E. Davis, D.D., of the Methodist Hospitals and Homes Association, Chicago, an expert on problems of hospital organization and administration, spoke before a large gathering on Sunday afternoon. The title of his address was "Essentials in Hospital Organization." A representative of the Southern Presbyterian Mission Board, Mrs. Martin, told of her work and of the need of doctors and nurses in Central Africa where the majority of deaths occur from preventable diseases and where seventy per cent of the infants are said to die because of the ignorance of parents in their proper care.

Monday morning brought the closing general session of the Protestant convention with its program of addresses, round table led by Dr. James R. Alexander of the Presbyterian Hospital, Charlotte, N. C., election of officers and transaction of general business.

"The Place of the Steward in the Hospital" was the topic assigned to the Rev. C. O. Pederson of Norwegian Lutheran Hospital, Brooklyn, and his remarks were of practical worth to the superintendents. He stressed the wisdom and economy of competitive buying, the need of a careful check on waste food and similar problems of efficient operation.

In the open discussion that followed Mr. Bauernfeind of Chicago called attention to the need of constant vigilance over the garbage can and other points of leakage. Miss Alice Thatcher of Christ Hospital, Cincinnati, outlined the duties of the housekeeper as she sees them. Dr. Alexander of Charlotte, N. C., emphasized the necessity of the superintendent himself knowing how to buy before he can train or judge a steward properly. At St. Luke's Hospital, Cleveland, said Superintendent Hildreth, requisitions for food supplies and all articles must of routine pass through the superintendent's office.

Moral Problems of Nursing Students

The paper prepared by Miss Maude Lucile Howell of Milwaukee on "The School for Nurses" was lost in transit, but her hastily sketched substitute was warmly received. It was a plea to training school superintendents to inculcate the ideals of their profession into the newest probationers and by educational and psychological methods to lead them constantly and steadily toward high standards of conduct.

Smoking, drinking, late hours, vulgarity—these were some of the charges brought by this non-sectarian hospital supervisor against the graduates of church training schools. Her accusations brought prompt rebuttal from various sources. Numerous suggestions for curbing tendencies toward irregularities of conduct were offered. Dr. Alexander and E. S. Gilmore saw the remedy in a careful choice of superintendents of nurses who can by percept and example guide the students into habits of refinement. C. W. Williams of Boston told of his hospital's careful entrance requirements which call for letters of recommendation from the pastor, physician and friends of the prospective student. Miss Pierce of Children's Hospital, Cincinnati, spoke a good word for alumnae registries, declaring that a private duty nurse who is recommended by an alumnae registry is sure to have high standards of conduct. Dr. B. A. Wilkes of the Missouri Baptist Sanatorium threw a bomb into the convention when he stated with some emphasis that hospital work is demoralizing to nurses. Only the gavel of the chairman, hastening the belated program, saved Dr. Wilkes from a concerted counter-attack.

In a brief discussion of the advantages and disadvantages of interdenominational hospitals, the ayes and the nays seemed to number equally. The Rev. Mr. Pederson sees in the interdenominational hospital the entire escape of institutions from church influence. Mr. Clarence H. Baum of Danville, Ill. thinks the interdenominational institution a worthy goal.

What Is Christian Medical School?

A question box brought out a variety of subjects, mostly touching the hospital in its ecclesiastical relations. A query on the establishment of Christian medical schools led to a short debate between Dr. Woods and the Rev. H. L. Fritschel. Dr. Woods sees the Christian hospital as any institution which is not Mohammedan, Buddhist, or some great non-Christian religious group. Most medical schools in this country are connected with universities, he declared, and they must surely be giving medical instruction in a Christian fashion. The Rev. H. L. Fritschel does not feel that he would like to subscribe to the particular philosophy of some medical professors in American universities.

A show of hands on the question of furnishing nurses' uniforms showed that half of the superintendents present followed that practice in their institutions. With but few exceptions, all give nurses some allowance in the way of money, uniforms or books.

A fair majority raised their hands in affirmation to the question of providing some religious instruction in their nursing curriculum. The keeping of records in their hospitals is largely in the hands of librarians, another question brought out. Opinion on the proper amount for the endowment of ward beds and private rooms brought answers ranging from $5,000 for ward beds and $10,000 for private rooms to $10,000 for ward beds and $20,000 for private rooms.

Mr. Pitcher found occasion through the round table discussion to tell of the apparent success of the Philadelphia experiment in a joint nurses' training course.

The next convention of the association will be held in conjunction with the American Hospital Association, the date and place to be fixed by the board of trustees.

LEADERS IN CALIFORNIA HOSPITAL BETTERMENT MOVEMENT MEET IN ANNUAL CONFERENCE

THE second annual convention of the hospitals of California was held under the auspices of the League for the Conservation of Public Health at the Maryland Hotel in Pasadena, September 5-8. The convention was most enthusiastic and was successful from whatever angle viewed. Over 300 hospitals were represented by more than 800 delegates and other representatives. Hospitals from all parts of the state and of every class and condition were included. The outstanding feature of the program was that there were no long papers; in fact, very few printed papers were read.

The convention hinged around the discussion of various important problems connected with hospitals. Certain experienced persons were invited to open the discussion of each subject with an address of ten minutes or less; other discussants were allowed four minutes. Every problem mentioned in the program was discussed fully.

In opening the convention the chairman, W. E. Musgrave, made the following statement:

In order that we may visualize the magnitude of the problems involved in the campaign of Hospital Betterment in California to which the League for the Conservation of Public Health is dedicated, let me present a few outstanding facts and figures which tell the story of hospital and health work in this state:

Totals of a few items of the annual cost of sickness and health to the people of California:

Maintenance of hospital beds	$ 60,000,000
Official public health	12,000,000
Laboratories, etc.	5,000,000
Nurses' fees and nurses' maintenance	5,000,000
Semi-trained nurses' fees	1,000,000
Hospital upkeep	10,000,000
Physicians' fees	15,000,000
Collected and expended by voluntary medical, health and medical welfare organizations	5,000,000
	$113,000,000

These conservative figures show that the people of California are annually contributing and paying in taxes over $28 for each man, woman and child for a few of the services of health."

Physicians Ample for Population

In regard to physicians there are for approximately 4,000,000 people in California:

8,000 physicians in the state.
7,000 of these are licensed to practice medicine.
About 5,000 are in active practice.
About 4,000 are members of the California Medical Society.
There is one physician in active practice to each 800 of population.
$3,000 is the estimated annual gross average income of physicians of the state.
$15,000,000 represents the aggregate annual gross income of all the physicians of the state.

The above statistics show that California has an adequate number of educated physicians. The number of physicians is increasing faster than the population.

Based upon the law of averages and available statistics, it is conservatively estimated that there are:

120,000 people ill all the time in California.
900,000 people are ill every year.

The expenses for physicians' fees for sick people, therefore, average $15+ per annum per person. This, of course, is but a minor fraction of the total cost of sickness. This does not include the more than $5,000,000 of free service rendered annually by the medical profession of the state."

As to nurses there are:

About 5,000 registered nurses in the state.
About 3,000 nurses are on duty with the public, exclusive of those on salaries in hospitals.
$1,500 is the estimated average annual income and maintenance of a nurse.
$5,000,000 represents the aggregate gross income and maintenance of the nurses of the state.
$100,000 represents the aggregate gross income of "practical nurses," etc.

Hospital and Sanatorium Statistics

There are 500 hospitals in the state, of all classes, kinds and conditions.
45,000 is the approximate number of hospital beds available for the sick.
35,000 is the approximate average number of hospital beds constantly occupied.
$4.50 is the average cost of maintaining a hospital bed for one day.
$160,000 is the estimated daily cost of maintaining all hospital beds of the state.
$60,000,000 represents the estimated aggregate annual cost of maintenance of all hospital beds of the state.
$5,000,000 represents the estimated cost of x-ray, laboratory fees, drugs, dressings, and other essentials of sickness, exclusive of those cared for in hospitals.
$10,000,000 represents estimate of the annual cost of upkeep for hospitals and sanitariums.
$160,000,000 represents the approximate amount invested in hospital buildings, equipment and real estate in California.
From $1,000,000 to $5,000,000 is invested annually in new hospitals and enlarging old ones in the state. This is a constantly increasing amount.
Exclusive of physicians, some 25,000 people are constantly employed in the hospitals alone in day and night service for the sick.
Over 90% of the hospitals are conducted at a financial sacrifice to their owners or supporters and to the medical profession that staffs them.

Twelve million dollars is a conservative estimate of the amount of money spent by state, county, municipal and other official health agencies in controlling disease.

Impressive as are the above figures of the costs of health to the people of California, many of the most expensive items incident to disease are not even mentioned. Some of these are:

The millions wasted by loss of earning time by patients, due to illness. If we consider that only 20,000 of the 120,000 people ill in the state all the time are earners and that they earn only an average of $5.00 a day, this item alone amounts to $37,000,000 a year for California.
The unknown millions spent for services of people, exclusive of physicians and nurses, whose earning time is lost in serving the sick.
Unknown millions spent for patent medicines, cure-alls and other self-prescribed treatments.
Unknown millions extracted by quacks, cultists and miscellaneous so-called doctors, healers, etc., of various species.
Unknown millions spent in visiting spas, mineral springs, health resorts and other sure-cures of disease and maintainers of health.
Millions spent in mineral waters, health water, freak foods, physical culture and various other combinations opposed to medicines.
Vast millions collected and spent by voluntary health organizations, legitimate and useful as well as illegitimate and vicious.

Condemn "Irregular Practice" Initiatives

A number of important resolutions were passed dealing with various problems confronting hospitals. Among the most important of these resolutions was one condemning the chiropractic, osteopathic and anti-vivisection initiatives, now before the people of California. Another was the unanimous endorsement and approval of the uniform clinical record system that has been prepared and endorsed by the Medical Society of California and issued by the League for the Conservation of Public Health. Another was the unanimous endorsement of the outline for "The Rating of Hospitals," published in part in the *Journal of the A. M. A.* of August 19, 1922, by Dr. W. E. Musgrave, and a recommendation that this outline be held as the ideal toward which all hospitals of California are working, and that the convention commend and endorse the work of the League in the Hospital Betterment Movement in California.

Other meetings held in connection with the convention were those of the Council of the Medical Society of California, a meeting of the League for Nursing Education, and a meeting of the Council of the State Society with the officers of all county societies of the state.

BRITISH COLUMBIA HOSPITALS ASSOCIATION MEETS AT NEW WESTMINSTER

THE annual convention of the British Columbia Hospitals Association was held at the Royal Columbian Hospital, New Westminster, B. C., August 29 to August 31. Attendance was good, more than thirty hospitals in various parts of the province having representatives present.

Mr. George McGregor, president of the board of directors, Provincial Royal Jubilee Hospital, Victoria, and first vice-president of the association occupied the chair in the absence of the president, Dr. H. C. Wrinch of Hazelton, who was unable to be present. He was greatly missed as was Dr. M. T. MacEachern, both having been identified with the association since its inception, and having contributed greatly to its success.

The meetings took place in one of the wards of the Royal Columbian Hospital transformed for the time being into an ideal auditorium. The corridors and adjacent rooms were alloted to the exhibitors, thus ensuring inspection of the exhibits by all who attended the sessions.

The opening session was devoted to the consideration of business administration and finance. Mr. George Haddon, managing secretary of the Vancouver General Hospital, presided, and gave an introductory address on hospital accounting under the government plan. This was followed by a thoughtful paper on "Auditing, Administration, and General Finance in Smaller Hospitals" by Mr. E. W. Carr Hilton, secretary of the King's Daughters Hospitals, Duncan, B. C. Mr. E. S. S. Withers, general manager of the Royal Columbian Hospital, spoke briefly on purchasing methods. Discussion was keen and very informative.

Part of the afternoon session was devoted to the consideration of nursing service, Miss K. W. Ellis, director of nursing of the Vancouver General Hospital, presiding. Miss Helen Randal, inspector of training schools for the British Columbia Graduate Nurses Association gave a resume of training school conditions in the province. Discussion was opened by Miss K. Stott, superintendent of nurses in the Royal Columbian Hospital. Marked interest was displayed, especially by members of boards of directors and it was apparent that conventions of this type when representatives are present from all departments of hospital activity provide an excellent opportunity for fostering mutual understanding and a spirit of cooperation.

Dr. George Drew, president of the Fraser Valley Medical Association, took charge of the conference on medical service which followed. Its main feature was an address by Dr. A. S. Monro of Vancouver on "The Patient as the Link of Cooperative Effort Between Hospital and Physician." At the evening meeting addresses of welcome were given by the mayor of New Westminster and by other representatives of public bodies. The provincial secretary, the Hon. J. D. MacLean, delivered an address in which he dealt with hospital problems in general with special reference to that of finance, outlining the plans of the provincial government in this connection. It was felt that the provincial government was in hearty accord with the hospital directorates of the province, and that certain measures would be taken that will ultimately prove of great assistance. Dr. T. R. Ponton, medical superintendent of the Vancouver General Hospital, spoke on standardization of hospitals, and the Rev. C. C. Owen delivered an inspiring address on "The Spirit of the Hospital."

On the succeeding day both morning and evening sessions were given up to the business affairs of the association The evening was devoted to the discussion of hospital economy from the standpoint of directors, physicians, nurses, and business managers. Mr. R. B. Leders, purchasing agent of the Vancouver General Hospital, gave an introductory address on hospital waste which provoked considerable discussion. Mr. J. J. Banfield, director of the Vancouver General Hospital, gave a witty speech on "Economy from the Director's Points of View," and Dr. W. B. Burnett of Vancouver gave a trenchant exposition of the physician's angle of the question. Miss Grace Kerr, superintendent of the Ladysmith General Hospital, brought out many practical points in her presentation of the nurse's point of view.

The morning session of the closing day of the convention was given over to the consideration of the problems associated with domestic management. Miss Ann MacArthur, superintendent of the Kootenay Lake General Hospital, presided and Miss M. Trood, chief dietition of the Vancouver General Hospital, delivered the introductory address. Discussion was opened by Mrs. M. P. Simpson, housekeeper of the Royal Columbian Hospital, who contributed some very practical and illuminating comment Dr. H. C. Steeves, superintendent of the Provincial Mental Hospitals, gave a most interesting description of the care of mental disease in British Columbia.

In the afternoon a conference on the organization and function of women's auxiliaries and other voluntary helpers took place. Mr. John Hanbury, president of the Women's Auxiliary of the Vancouver General Hospital, presided and delivered an introductory address. Discussion was opened by Mrs. A. W. Gray, president of the women's auxiliary of the Royal Columbian Hospital, New Westminister. Great interest was manifested in this session, and as a result, it was decided to admit duly authorized voluntary auxiliary bodies to corporate membership.

At the closing session an animated discussion took place concerning the disposition of moneys accruing to hospitals as the result of government liquor control. The present system of distribution was held to be unsatisfactory, and representations will be made to the government requesting certain changes.

The convention next year will meet at Penticton.

Officers of the ensuing year are: Dr. H. C. Wrinch, Hazelton, president; Mr. Charles Graham, Cumberland, first vice president; Mr. J. T. Robinson, Kamloops, second vice president; Mrs. M. E. Johnson, Vancouver, treasurer; and Miss Ethel Johns, Vancouver, secretary.

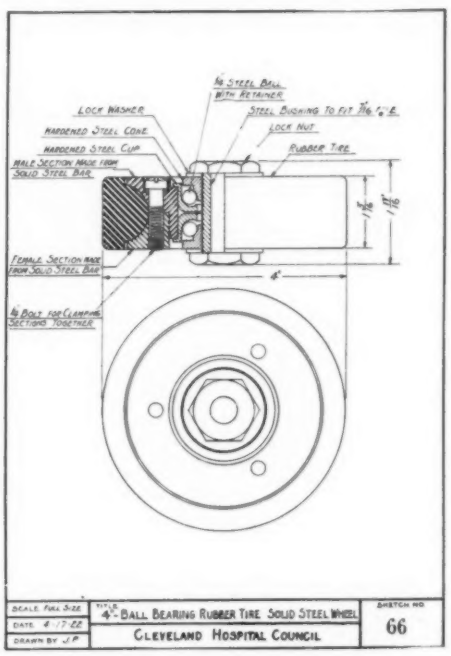
The members of the executive committee are the following:

Mr. R. A. Bethune, Kamloops; Miss Charlotte Black, Prince Rupert; Dr. P. Brown, Nanaimo; Rev. Father O'Boyle, Vancouver; Dr. M. T. MacEachern, Ottawa; Miss J. F. McKenzie, Victoria; Mr. George McGregor, Victoria; Miss Ann Mac Arthur, Nelson; Mr. E. S. Withers, New Westminister; and Mr. George Binger, Kelowna.

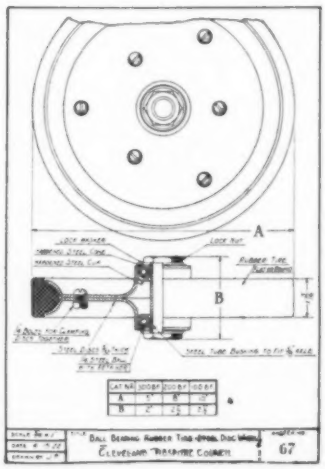
CLEVELAND HOSPITAL COUNCIL SETS STANDARDS FOR FURNITURE

THE Cleveland Hospital Council has recently announced the first results of its standardization program as applied to hospital equipment. The various items which have received the approval of the council include a number of wheel and caster sets and several types of wheeled furniture, including trucks, serving wagons, dressing carts and stretchers.

The importance of this announcement is to be measured rather as it indicates the tendency toward the standardization of hospital equipment, than because of the special merit of the approved designs and specifications. There undoubtedly is some benefit to be gained by the standardization of requirements on the part of a limited number of similar institutions. Likewise it is important that certain minimum standards of mechanical construction be established. Whether it is possible or practical to apply arbitrary fixed standards in the mechanical construction and design of hospital equipment to the entire field is a question on which much might be said.



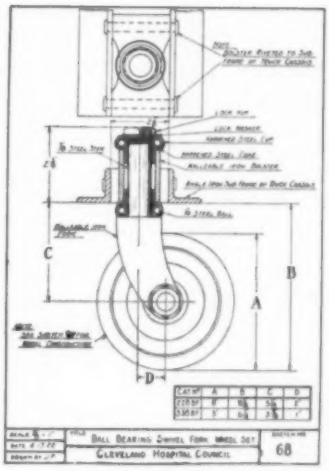
Sketch No. 66.



Sketch No. 67.

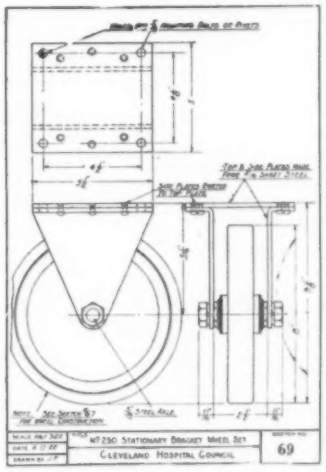
Many hospital executives will probably disagree with some of the detailed specifications. In fact, it is a question if the selected standards represent the latest and most approved ideas of construction in a number of instances.

It is interesting to note that the council virtually has begun its standardization effort with wheels and casters, and in fact most of the furniture items which have been approved are wheeled pieces. This decidedly is a step in the right direction because there has been a tendency on the part of hospital executives and purchasing agents to ignore the wheel and caster equipment of furniture, although such part of hospital furniture is called upon to withstand the most rigorous use.



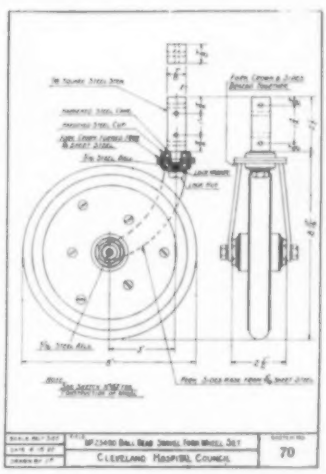
Sketch No. 68.

It would seem, however, that in preparing these standardized specifications greater attention has been paid to the wheel and caster equipment than to other essential specifications. For instance, many hospital executives will feel that the riveted construction shown on several of the trucks is more or less obsolete and scarcely to be compared with the welded construction so generally used at the present time. There is also some question of the desirability of certain designs, notably the linen hamper, as a number of other models on the market seem to offer greater advantages.



Sketch No. 69.

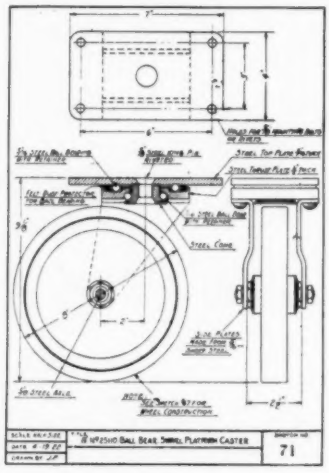
In consideration of wheels and casters emphasis has properly been laid on three essential features. Through the specification of ball-bearing hubs, easy running wheels are assured. The use of the pressed steel housing gives necessary strength without undue weight, and furthermore, enables the housing to be taken apart easily when renewing tires. The specifications, while emphasizing the necessity of quality in rubber tires, fail to give any details of specification for the rubber or rubber compound to be used.



Sketch No. 70.

Sketch 66 illustrates a

4" ball-bearing rubber tired wheel. The detailed drawing gives a clear idea of the method and type of construction with the possible exception, as mentioned above, of the quality of the rubber tires.

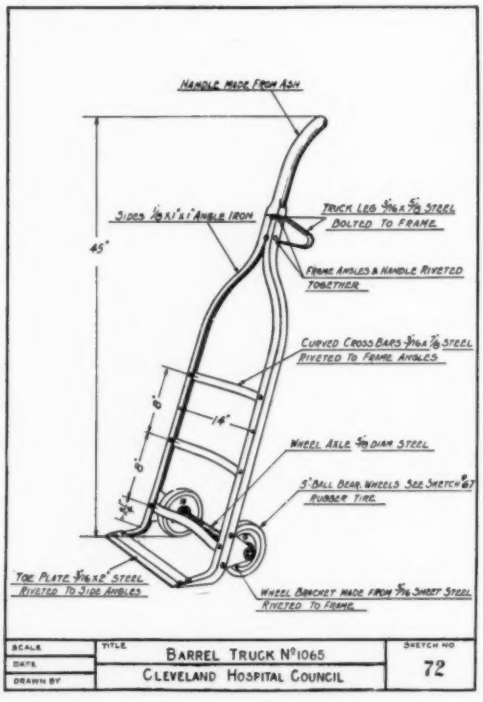


Sketch No. 71.

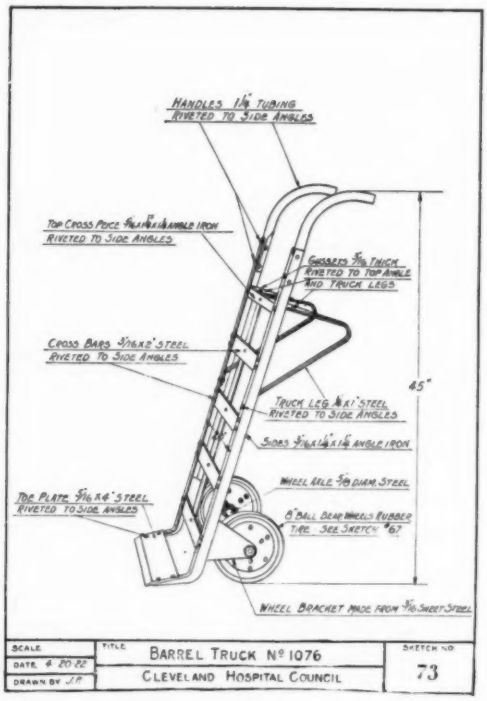
Sketch 67 presents the details of construction of 5", 8" and 10" ball bearing rubber tired wheels.

Sketch 68 illustrates the wheel shown in Sketch 67 assembled in a heavy duty ball-bearing swivel caster ready to attach to the angle frame of the truck chassis. It is to be noted that the illustration shows the angle frame members to which the castings are attached and also that the fork head projects above the frame members. This assembly is supplied for 4", 5", 8" or 10" wheels.

Sketch 69. This sketch illustrates the wheel shown on Sketch 67 assembled in a heavy duty stationary bracket ready to attach to truck chassis and is the same height as the bracket on the swivel sets shown in Sketches 68 and 71. This bracket is likewise made for 4", 5", 8" and 10" wheels.



Sketch No. 72.

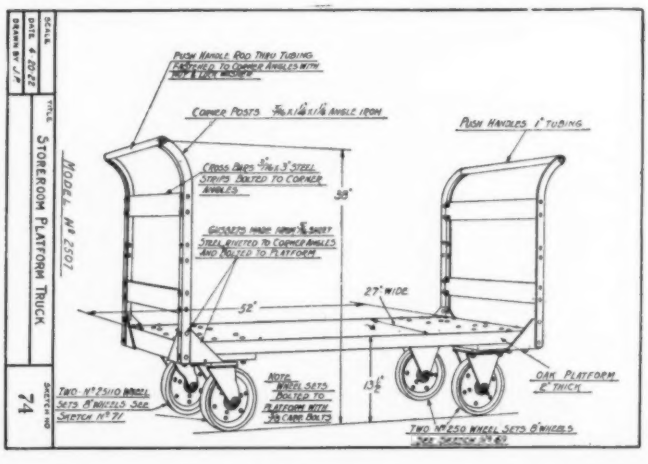


Sketch No. 73.

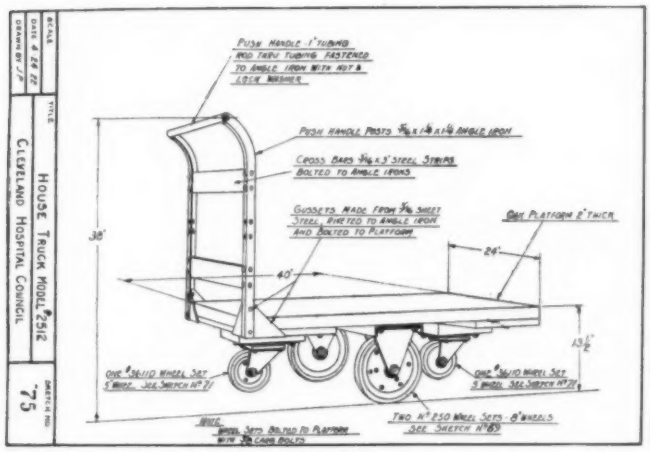
Sketch 70 illustrates the wheel shown in Sketch 67, except that the wheel is equipped with a round instead of a flat tire. In this illustration the wheel is mounted on a ball-bearing swivel fork, so designed that the stem may be securely fastened in the angle leg to permit the fork to swivel freely on the ball-bearing crown. The advantage of this type of swivel fork is that the stem does not swivel, but may be fastened securely, thus eliminating the noise and friction of a revolving form stem. This type of caster is also made in 4", 5", 8" and 10" wheels, and is made with a round stem instead of a square one as shown.

Sketch 71 illustrates a heavy duty ball-bearing swivel caster, ready to attach to the bottom of the truck. This design is especially adapted to heavy work where it is advisable to keep the platform of the truck as close to the floor as possible. The wheel is the same as illustrated in Sketch 67 and is made in 4", 5" or 8" size, matching up in height with the stationary set shown on Sketch 69.

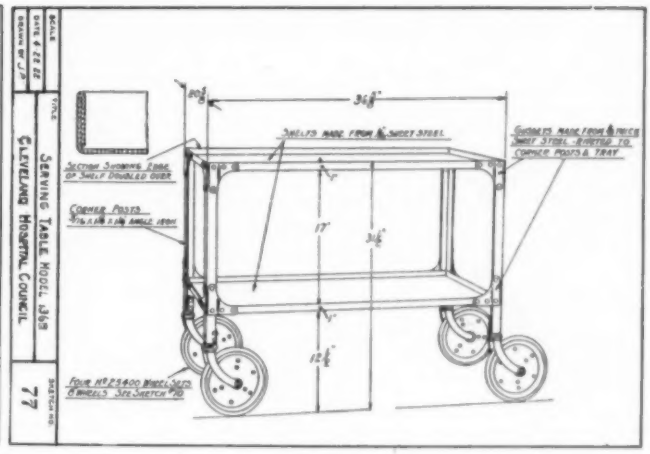
Sketch 72. This is a light weight general utility truck. It is claimed that this truck while easily handled will carry



Sketch No. 74.



Sketch No. 75.



Sketch No. 77.

an unusually heavy load. It is equipped with the ball-bearing wheels shown on Sketch 67.

Sketch 73 illustrates a heavy duty truck, likewise equipped with the wheels shown on Sketch 67.

Sketch 74 is a heavy service platform truck, equipped with two swivel casters as shown on Sketch 71, and two stationary casters as shown on Sketch 69. In both instances the wheels used are shown on Sketch 67.

Sketch 75 is the same general type as Sketch 74, except for the caster equipment and push handle. On this truck the stationary brackets are attached to the center of the platform with a swivel caster on each end. This permits turning the truck in its own length, which is a convenient feature.

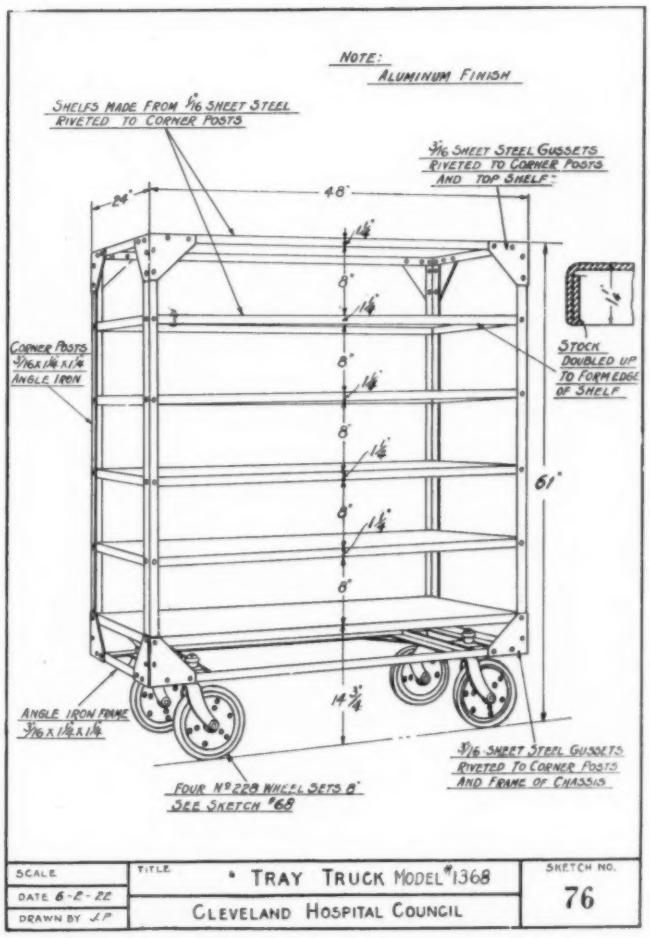
Sketch 76. This is a standard type of tray truck. The frame is made of steel angles supported by steel gussets running both ways at all corners. The shelves are made of one piece of sheet steel folded over on the sides and ends and turned up on the underside for extra strength, this feature being shown in small detail sketch. The chassis is equipped with four swivel casters as illustrated in Sketch 68, with both ball-bearing wheels and ball-bearing swivel fork heads.

Sketch 77 represents a plain, simple, yet substantial serving table. The details of construction are similar to the tray truck on Sketch 76, except that the shelves are assembled with the edges turned up forming a tray. The chassis is equipped with ball-bearing swivel casters as illustrated on Sketch 70.

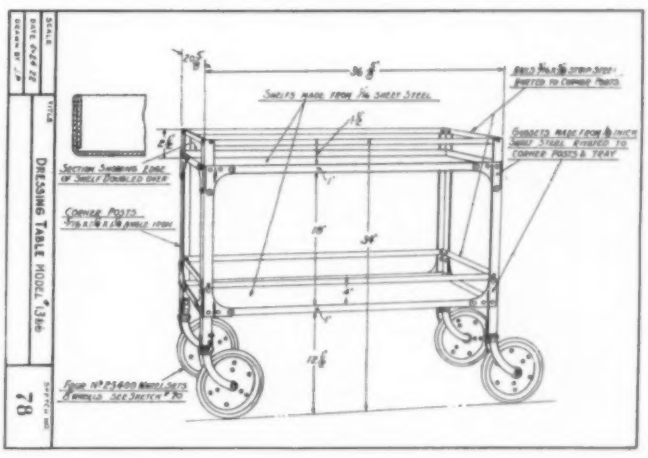
Sketch 78. This dressing table or carriage is of simple design. The trays are made of one-piece of sheet steel with a double fold of the stock on the sides and ends, and with every tray supported by steel gussets running both ways at each corner. The chassis is equipped with casters shown on Sketch 70.

Sketch 79. This dish truck is designed for heavy duty with the elimination of all unnecessary noise. The wheel equipment is illustrated on Sketch 68 and Sketch 69. The frame is of angle steel, the shelves being made of strap steel, rivetted to side angles.

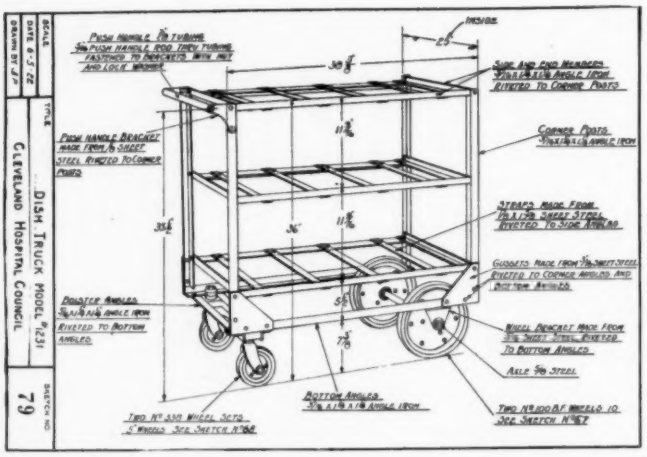
Sketch 80 shows the wheel stretcher. Sketch 80-A shows



Sketch No. 76.

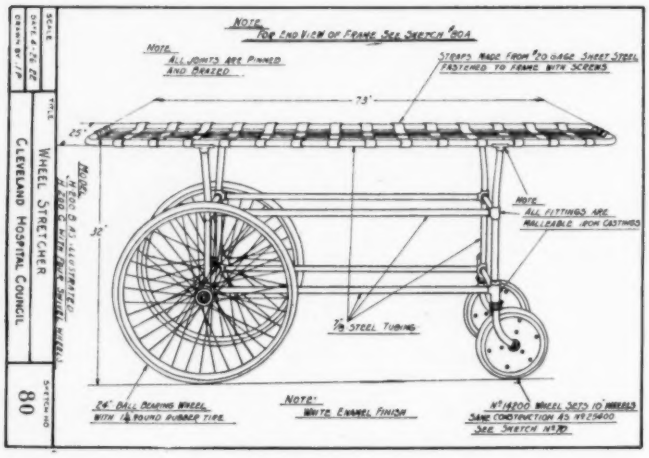


Sketch No. 78.



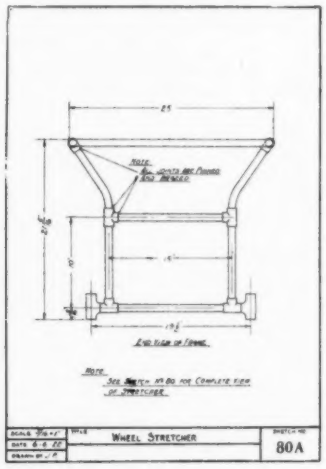
Sketch No. 79.

the detailed construction of the frame which is made of steel tubing, each joint pinned and brazed. The stretcher is made either with stationary top as shown in illustration



Sketch No. 80.

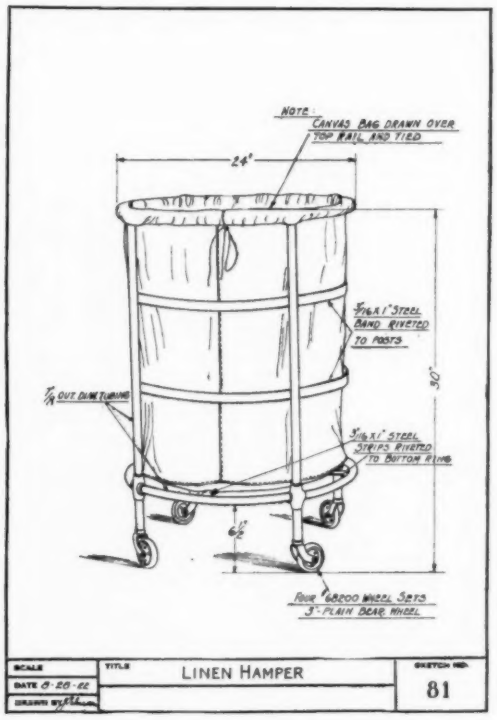
or with auxiliary removable stretcher top. The chassis is equipped with service wheel sets as shown on Sketch



Sketch No. 80A.

70 with heavy duty ball-bearing wheels on the stationary axle.

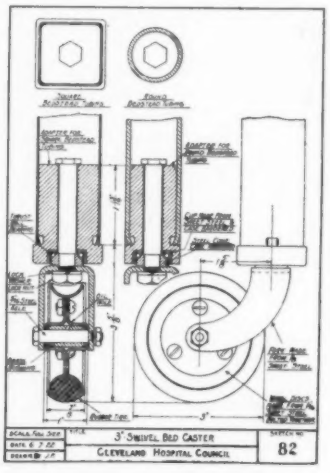
Sketch 81. This linen hamper is constructed of steel tubing, all joints brazed, forming a cage that is light in



Sketch No. 81.

weight and strong. The chassis is equipped with wheel sets as illustrated in Sketch 82.

Sketch 82. This is a ball-bearing swivel bed caster, which is designed to move a heavy load easily and quietly. The wheel is substantially made and may be easily taken



Sketch No. 82.

apart for tire replacement. The bearing is unusually large and fits the axle perfectly, which will insure a quiet, easy running wheel. The fork swivels on ball-bearings which are machined, turned and hardened.

What would life be without loyalty? Loyalty is the finest fibre in the human breast; it awards alike the humble and the great; makes the small man big and the big man bigger. Take loyalty from the heart of a saint, and you have the likeness of a devil. The greatest thing in life is man's loyalty to man, that hearty quality of true manhood, that innate stamp of fair play which prompts us to hand out the square deal instead of the double cross.

DIETITIANS TO ASSEMBLE AT NATION'S CAPITAL FOR FIFTH ANNUAL SESSION

WASHINGTON, D. C. with its stately temples of government will furnish the background for the fifth annual convention of the American Dietetic Association to be held October 16-18, although on the closing day of the conference the scene will shift to Baltimore and Johns Hopkins Hospital. Final preparations are being made for what it is hoped will be the largest single gathering of dietitians ever assembled.

The New Willard Hotel, one of the country's finest hostelries, is to be the convention headquarters, and the majority of delegates have reserved rooms under that roof. The Raleigh, the New Ebbitt and Grace Dodge Hotel are also well booked up for the convention dates.

The program, which is printed in full below, gives promise of great profit to dietitians, both in subject matter and speakers. Sidetrips to the home economics bureau of the U. S. department of agriculture and to Walter Reed Hospital in Takoma Park also will take the interest of all the delegates.

Government personages in the field of health and hospital service will be guests of honor and speakers at a banquet on the opening night of the convention, at which the president, Mrs. Mary de Garmo Bryan will preside; among them are Surgeon General Hugh S. Cumming of the U. S. Public Health Service; Major Julia C. Stimson, superintendent of the Army Nurses' Corps; Mrs. Lenah Higbee, superintendent of the Navy Nurses' Corps; and Miss Lucy Minnegerode, superintendent of Public Health Service Nurses' Corps.

MARY DE GARMO BRYAN
President, American Dietetic Association.

Social events will reach the climax on Wednesday afternoon of the convention when Mrs. John D. Rockefeller Jr., assisted by Mrs. Calvin Coolidge, wife of the vice president; Mrs. Henry C. Wallace, wife of the secretary of agriculture; and Mrs. Hugh S. Cumming, wife of the surgeon general of the U. S. P. H. S., will entertain the delegates at tea at the Grace Dodge Hotel.

After the inspection trips to the Walter Reed General Hospital and the department of agriculture on Tuesday a picnic supper is to be served.

On Thursday the entire association will be the guest of Johns Hopkins Hospital in Baltimore. A morning program will be held at the hospital auditorium with two professors at the Johns Hopkins medical school as speakers. The dietitians will have luncheon in the hospital and will spend the afternoon at the hospital and clinic.

Will Hear Report on Italian Diet

One of the events on the general program of addresses which will be awaited with interest is the report of the Committee on Italian Dietary Survey of which Mrs. Gertrude G. Mudge is the chairman. Members of the committee are: Reba Reed, Association for Improving the Condition of the Poor, New York; Mrs. W. B. S. Thomas, New York; Pearl Shackelford, student dietitian at Peter Bent Brigham Hospital, Boston; Ruth A. Johnson, assistant director of the Visiting Housekeepers' Association, Detroit; and Fairfax Proudfit, of the out-patient department, University of Tennessee Hospital, Memphis.

Officers of the American Dietetic Association for 1922 are: president, Mrs. Mary de Garmo Bryan; first vice president, Miss Helene Pope; second vice president, Miss Octavia Hall; secretary, Miss E. M. Geraghty; treasurer, Miss Ellen M. Gladwin.

The program follows:

MONDAY, OCTOBER 16

10 a. m.

Dr. Ruth Wheeler, University of Iowa Medical College, Iowa City, presiding.

Education section.

"The Dietitian—a History."
Agnes O'Dea, Johns Hopkins Hospital, Baltimore.

"The Dietitian—a Statistical Study."
Breta M. Luther, Cook County Hospital, Chicago.

"The Dietitian—A Prophecy."
Ruth Wheeler, professor of nutrition, University of Iowa Medical College, Iowa City.

2 p. m.

Helene Pope, Margaret Morrison College, Pittsburgh, presiding.

Program.

"The Dietitian and the Diabetic."
Elliot P. Joslin, M.D., Boston.

"A Nutrition Experiment in Industry."
Laura Comstock, Eastman Kodak Company, Rochester, N. Y.

"Atmosphere and Personality in the Tea Room."
Laura N. Piper, manager, Laura Matilda Tea Room, New York.

"Findings in China."
Emma Gunther, Teachers College, Columbia University, New York.

"Housewifery in China."
Ray Balderston, Teachers College, Columbia University, New York.

7 p. m.

Mary DeGarmo Bryan, Jersey City, N. J., presiding.

Dinner at New Willard Hotel. Speeches by

Hugh S. Cumming, M.D., Surgeon general, U. S. Public Health Service, Washington.

E. M. GERAGHTY
Secretary, American Dietetic Association.

Major Julia C. Stimson, superintendent, Army Nurses Corps, U. S. A.

Mrs. Lenah Higbee, superintendent, Navy Nurses Corps, U. S. N.

Miss Lucy Minnegerode, superintendent of nurses, U. S. Public Health Service.

TUESDAY, OCTOBER 17

9:30 a. m.

Rena Eckman, director of housekeeping and dietetics, University of Michigan, Ann Arbor, presiding.

Dietotherapy administrative section.

"The Role of High Protein in the Etiology of Nephritis."
L. H. Newburgh, M.D., University of Michigan Hospital, Ann Arbor.

"A Laboratory for the Preparation and Service of Research Diets."
Dorothy M. Stewart, department of dietetics, University of Michigan, Ann Arbor.

"Hospital Food Costs."
Leroy E. Perkins, M.D., assistant superintendent, Peter Bent Brigham Hospital, Boston.

"Getting Food to the Patients."
Henry C. Wright, Hospital and Institutional Bureau of Consultation, New York.

2 p. m.

Visits to Walter Reed General Hospital and Office of Home Economics, U. S. Department of Agriculture.

8 p. m.

Octavia Hall, Peter Bent Brigham Hospital, Boston, presiding.

Program.

"Nutrition and Diet in Childhood."
Mary S. Rose, Teachers College, Columbia University.

"The Relation of Hygiene to the Growing Child."
Alfred Hess, M.D., New York.

WEDNESDAY, OCTOBER 18

10 a. m.

Mrs. Gertrude G. Mudge, Committee of Italian Dietary Survey, presiding.

Social service section.

Presentative of Committee Report of Italian Dietary Survey. Gertrude G. Mudge, chairman; committee members: Reba Reed, Association for Improving the Condition of the Poor, New York; Mrs. W. B. S. Thomas, New York; Pearl Shackelford, student dietitian, Peter Bent Brigham Hospital, Boston; Ruth A. Johnson, assistant director, Visiting Housekeepers' Association, Detroit; Fairfax Proudfit, Out-Patient Department, University of Tennessee Hospital, Memphis.

"The Interrelation of the Dietitian and the Medical Social Worker."
Ida M. Cannon, director of social service, Massachusetts General Hospital, Boston.

"Factors Other than Food in the Nutrition Problem."
Lucy Gillett, director Nutrition Bureau, A.I.C.P., New York.

"Nutritional Activities in Philadelphia."
Anna Louise DePlanter, Child Federation, Philadelphia.

"Psychological Aspects of Some Problems in Dietary Administration."
John B. Watson, M.D., J. Walter Thompson Co., New York.

2 p. m.

Mrs. Mary DeGarmo Bryan, presiding.

Program.

"Hunger and Thirst."

ELLEN M. GLADWIN
Treasurer, American Dietetic Association.

A visit will be paid by delegates to the Walter Reed General Hospital, of which the above is an airplane view.

Walter Cannon, M.D., professor of physiology, Harvard Medical School, Boston.

Business meeting.

Reports of committees.

Tea (5 p. m.) Served by

Mrs. John D. Rockefeller, Jr., hostess.
Mrs. Calvin Coolidge.
Mrs. Henry C. Wallace.
Mrs. Hugh S. Cumming.

8 p. m.

Genevieve Field, Walter Reed General Hospital, Washington, D. C., presiding.

All-member program.

"The Food Service for Private Patients."
Lulu Graves, supervising dietitian, Mount Sinai Hospital, New York.

"The Food Service for Ward Patients."
Marjory Hulsizer, dietitian, Barnes Hospital, St. Louis.

"The Food Service for School Children."
Daisy Treen, director, School Lunch and New England Kitchen, Women's Educational and Industrial Union, Boston.

"The Food Service for the Hotel."
Mary Lindsley, manager, Grace Dodge Hotel, Washington, D. C.

THURSDAY, OCTOBER 19

(Johns Hopkins Hospital, Baltimore.)

10 a. m.

Lulu Graves, supervising dietitian, Mount Sinai Hospital, New York, presiding.

Program.

"The Relation of Animal Experimentation to Dietetics."

The final day's session will be held at Johns Hopkins Hospital in Baltimore.

E. V. McCollum, M.D., professor of chemical hygiene, Johns Hopkins Hospital, Baltimore.
"The Relation of the Medical Staff and Diet School in Johns Hopkins Hospital."

New Willard Hotel at Washington is convention headquarters.

William S. McCann, M.D., associate physician, Johns Hopkins Hospital.

12:30 p. m.

Luncheon.

2 p. m.

Inspection of hospital and clinic.

NEWS ITEMS

The September meeting of the Chicago Dietetic Association was held at the Hospital Library and Service Bureau on the evening of Friday, September 15. Those attending this meeting had the privilege of hearing Dr. Solomon Strouse describe the treatment of nephritis. Dr. Strouse explained the newer methods of treating diabetes.

The Chicago program for the coming year will include discussions by the best medical men in the city on the treatment of diabetes, nephritis and gastro-intestinal disorders.

The July meeting was held at the Social Workers Country Club at Riverside, Ill., where canoeing on the silvery Des Plaines and woodland festivities in the adjoining forest preserve were the order of the day. The meeting adjourned later to partake of a delicious repast, doubly enjoyable because of the cook, who, knowing nothing of dietetics, omitted all calories, proteins, carbohydrates and served only food.

Personals

Miss Breta Luther, vice president of the Chicago association and former dietitian at Cook County Hospital, has accepted a position at the Children's Hospital in Boston. She is succeeded at Cook County by Miss Marie Youmans who has been assistant dietitian at Johns Hopkins Hospital, Baltimore. Miss Sadie Hahn from Peter Bent Brigham, Boston, is her assistant.

Miss Kate Helzer is equipping the kitchen and organizing the dietary department at Polyclinic Hospital, New York. Miss Helzer gave up her position at Western Pennsylvania Hospital, Pittsburgh, to study at Columbia during the summer.

Miss Gertrude Oehmig severed her connection with the hospital at Shreveport, La., and is managing a cafeteria in Chattanooga, Tenn.

Miss Elizabeth Cooper, formerly assistant dietitian at Methodist Hospital, Brooklyn, is now dietitian at St. Bartholomew Hospital, New York.

Miss Carolyn Kling of Grace Hospital, Detroit, and Miss Maud Shackett of Herman Kieter Hospital, have joined the Hotel Statler organization.

PUBLIC HEALTH WORKERS WILL ASSEMBLE AT CLEVELAND

Cleveland, Ohio, will be host to the American Public Health Association at its fifty-first annual meeting on October 16-19. Association headquarters are at the Hotel Statler.

Addresses of welcome, according to the preliminary program, will be made by Dr. J. J. Thomas, representing Cleveland social, medical and health groups; Newton J. Baker, former secretary of war, who is president of the Cleveland Chamber of Commerce; and Ralph Perkins, chief of the department of public welfare of Cleveland. Dr. A. J. McLaughlin of Washington, D. C., is the president.

Comprehensive programs have been outlined for the various sections: public health nursing, industrial hygiene, food and drugs, vital statistics, child hygiene, sanitary engineering, public health administration, and health, education and publicity. The section on industrial hygiene will hold joint sessions with the Ohio Association of Industrial Physicians of which Dr. Sydney S. McCurdy, medical director of the Youngstown Sheet & Tube Company, is the president. Dr. Wade Wright of the Harvard School of Public Health is chairman of the industrial section.

R. E. Doolittle of the U. S. Department of Agriculture, Bureau of Chemistry, is chairman of the food and drugs section at which some important reports are to be presented. The chairman of the sanitary engineering section is W. H. Dittoe of the state department of health, Columbus, Ohio.

John Dill Robertson of Chicago is chairman of the public health administration section.

MISSISSIPPI VALLEY CONFERENCE ON TUBERCULOSIS MEETS

The Mississippi Valley Conference on Tuberculosis holds its annual session October 9-11 in Milwaukee, with President Robinson Bosworth, M.D. of St. Paul in the chair. Concurrently on the final day of the meeting will be held the annual conference of the Mississippi Valley Sanatorium Association. The latter organization will hold its morning session at Muirdale Sanatorium and conference in the afternoon at Blue Mound Sanatorium, both at Wauwatosa. Hotel Phister in Milwaukee is the headquarters of the main convention.

Among the speakers are Owen R. Lovejoy, general secretary of the National Child Labor Committee; Dr. Linsley Williams, managing director of the national association; Philip P. Jacobs, publicity director of the national organization; and C. M. DeForest, Modern Health Crusade executive of New York.

At the nurses' meeting scheduled for the Wednesday afternoon (October 11) session, Mrs. Mary P. Morgan, director of the bureau of child welfare and public health nursing of the Wisconsin State board of health, will preside. A debate will make up the major part of the program, the question being: "Resolved: that tuberculosis nursing is more effective when it is specialized than when it is part of a generalized program."

Dr. A. T. Laird, superintendent of Nopeming Sanatorium in Nopeming, Minn., is president of the sanatorium association and will preside at its sessions.

CLINICAL CONGRESS WILL CONSIDER HOSPITALS

FOLLOWING the custom established last year at Philadelphia, the first day's program of the Clinical Congress of the American College of Surgeons will be devoted entirely to hospital matters. The Congress will be held in Jordan Hall, Boston, October 23-27.

Dr. Frederick W. Slobe of the College has announced the following tentative program for the hospital conference:

9:30 to 12:30 a. m.

President, John B. Deaver, M.D., F.A.C.S., presiding.

Report of the Standardization Activities of the College in 1922.
Franklin H. Martin, M.D., F.A.C.S., director-general, American College of Surgeons, Chicago.

The Doctor and the Hospital.
Frederic A. Washburn, M.D., superintendent, Massachusetts General Hospital, Boston.

The Minimum Standard and its Application to Hospitals.
Frederick W. Slobe, M.D., hospital standardization department, American College of Surgeons, Chicago.

What Real and Lasting Benefit Has Come to the Patient from Hospital Standardization?
Rev. Charles B. Moulinier, S. J., president, Catholic Hospital Association, Milwaukee.

The American Hospital.
A. R. Warner, M.D., executive secretary, American Hospital Association, Chicago.

Hospital Standardization from a Public Health Standpoint.
D. A. Craig, provincial commissioner, Nova Scotia Division, Canadian Red Cross, Halifax, Nova Scotia.

Hospital Standardization from the Viewpoint of the Medical Staff.
R. A. Hughes, M.D., Moncton, New Brunswick.

Sidelights on Hospital Standardization.
Robert Jolly, superintendent, Baptist Hospital, Houston, Texas.

The Analysis of End Results.
Eugene H. Pool, M.D., F.A.C.S., New York.
E. A. Codman, M.D., F.A.C.S., Boston.

General Summary of Hospital Standardization.
Malcolm T. MacEachern, M.D., C.M., director-general, Victorian Order of Nurses for Canada, Ottawa.

2 to 4:30 p. m.

Round table discussion conducted by M. T. MacEachern, M.D., C.M.

The round table discussion will be confined largely to the requirements of the minimum standard. Hospital superintendents, staff members and members of boards of trustees, are urged to send in questions which they desire to be answered, in order that the discussion may shed light on the various difficulties encountered. After representative speakers have opened the discussion of these questions, the subsequent discussion will be open to all. A tentative list of the topics to be considered follows:

Staff organization.
1. The selection of the exact type of staff organization best suited to local needs.
2. The division of responsibility into representative committees.
3. The initial organization of the staff conference.
4. The agenda and description of the staff conference.
5. Methods of stimulating interest in staff conferences.
6. Monthly analysis of hospital work.

Case records.
1. The component parts of a case record.
2. Methods of securing the records.
3. Methods of stimulating increased interest in records.
4. The hospital historian or record clerk.
5. Filing systems, card indices, disease nomenclatures and follow-up systems.

Laboratories and x-ray facilities.
1. Methods of stimulating increased use of laboratories by the medical staff.
2. Relationship of laboratory charges to laboratory service, and the various systems of laboratory charges commonly employed.
3. The extent to which routine laboratory examinations should be employed.
4. Laboratory facilities in the small hospital.
5. Laboratory reports and filing systems.
6. What should constitute the complete service in an x-ray department?
7. The interpretation of x-ray plates by roentgenologists versus interpretation by individual physicians.
8. To what extent can x-ray facilities outside of the hospital be used satisfactorily.

Miscellaneous.
1. What points in particular should the hospital surveyor investigate in making his annual visit.
2. Making the public understand the value of hospital standardization.
3. Methods of increasing the efficiency of the hospital survey of the College.

Including the speakers of the morning program, the following names are a partial list of those who have been invited to lead in the discussion:

John M. Baldy, M.D., F.A.C.S., Philadelphia.

John G. Bowman, chancellor, Pittsburgh University, Pittsburgh.

John F. Bresnahan, M.D., Superintendent, Bridgeport Hospital, Bridgeport, Conn.

Frank E. Chapman, superintendent, Mount Sinai Hospital, Cleveland.

Pliny O. Clark, president, Protestant Hospital Association.

Rev. Newton E. Davis, Chicago.

E. T. Dillon, M.D., F.A.C.S., Los Angeles.

Matthew O. Foley, managing editor, *Hospital Management*, Chicago.

S. S. Goldwater, M.D., superintendent, Mount Sinai Hospital, New York.

Charles A. Gordon, M.D., F.A.C.S., Brooklyn.

R. M. Harbin, M.D., F.A.C.S., Rome, Ga.

A. K. Haywood, M.D., superintendent Montreal General Hospital, Montreal.

Joseph B. Howland, M.D., superintendent, Peter Bent Brigham Hospital, Boston.

Roy C. Kingswood, M.D., London, Ontario.

Henry M. Pollock, M.D., superintendent, Massachusetts Homeopathic Hospital, Boston.

W. C. Rappleye, Rockefeller Foundation.

Brigadier General C. E. Sawyer, M.C., U.S.A.

George W. Swift, M.D., F.A.C.S., Seattle.

Joseph J. Weber, editor, THE MODERN HOSPITAL, Chicago.

H. E. Webster, superintendent, Royal Victoria Hospital, Montreal.

Horace G. Wetherill, M.D., F.A.C.S., Denver.

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Department of Nursing Education, College for Women,
Western Reserve University, Cleveland, Ohio

WHY MANY NURSES HAVE SHUNNED THE FIELD OF MENTAL HYGIENE

BY HARRIET BAILEY, R.N., EDUCATIONAL DIRECTOR OF NURSES, BELLEVUE AND ALLIED HOSPITALS, NEW YORK.

WITH great interest I have read the article of Dr. Vernon Briggs, "Mental Hygiene in its Relation to Present-day Nursing," in the September issue of THE MODERN HOSPITAL; and while I am impressed with the fairness and justice of much that he says, it seems to me there are some things which should be offered in explanation of the present situation in mental nursing, for the problem he presents cannot be solved by the nursing group alone.

Inasmuch as nursing has ever been the "hand maiden of medicine" it is not to be expected that the nursing of mental patients could reach a higher level than the medical care and treatment which for so long a period made little advancement in the scientific study and treatment of these diseases. For too long hospitals for mental patients, "asylums" so-called, were little more than places of detention to which all those unfortunate individuals in the community who were unable to adapt themselves to the ever changing complexities of their social environment were, after being adjudged insane, committed under the provisions of the law for a period limited only by their ability to regain their mental health; and, I may add, with little more help in doing so than the nursing staff could offer.

Mental Hospital Conditions Not Attractive

The nursing care at this time consisted mainly of preventing these patients from harming others or injuring themselves, of seeing that they received a reasonable amount of food, were kept clean and performed as much work for the institution as they were able. To prepare the nurse for this care a few classes were given in which the care of the keys, simple precautions against accidents and escapes, and various aspects of hospital housekeeping were emphasized.

Until comparatively recently the state hospitals and a limited number of private hospitals offered the only opportunities for young women to obtain training and experience in this branch of nursing. Training schools for nurses existed in some of these, but the educational standards were for the most part below those of the majority of general hospital training schools.

It is not primarily because of fear or prejudice that young women have not chosen to undertake the care of patients in mental hospitals, but because the conditions within these hospitals have not been such as to attract them. It is not so many years since these nurses were expected to be on duty for twelve to fourteen hours daily, and at the end of busy and oftentimes strenuous days to retire to their rooms which were situated on the wards, very often wards in which the patients were noisy and disturbed. They had always the expectation of being called at least one or more times during the night to assist in the management of difficult and excited patients. The nurses' comfort was the last consideration, nor were any opportunities provided for recreation. They were supposed to have some mysterious springs of refreshment and vitality which could recreate them under these trying conditions, renew their patience and strength, and make them fit to take up the arduous duties of the following day.

Nurse's Position Has Been Subordinate

Then, too, the nurses in many mental hospitals have been, and now are, too often looked upon as subordinates, not as co-workers. They have been made to feel that they must obtain all their initiative from the physicians; that they are principally makers of beds and dispensers of food and drugs. The patient's illness is rarely discussed with them. They never read a history. They know little or nothing of the onset of the illness, the factor or factors which precipitated it or those which are active in prolonging it. Very little instruction is given to help them to recognize and interpret the mental symptoms, or to apply the most apparent and needful nursing measures.

What incentive, I ask, can there be for young women to enter upon a work, or keep at it, in which they may be scratched, kicked, spat upon, have their hair pulled and clothing torn, unless they are able to interpret these acts as the expressions of serious mental illness and not of temper or bad disposition?

How can we expect a nurse to spend long hours with patients who are acutely depressed, or acutely excited, or indifferent or apathetic, and find at every turn that her efforts at amelioration are blocked because she has no understanding of the mechanism of disordered behavior, emotions or intellect? No nurse will shirk or shrink from hard or disagreeable duties if by the performance of these tasks she is able to relieve the mental distress and assist the patient back to health. For, after all factors are considered, this provides the largest compensation in nursing service, for it brings contentment and satisfaction and

arouses enthusiasm without which much of the work would descend to the level of drudgery.

One nurse of much intelligence and many years of administrative experience in mental hospitals has recently said:

"If spontaneously one of the physicians should ask me for reactions or discuss with me a patient's condition, I would mentally swoon, the shock would be so great. The result to me? I am in a state of stasis. Progress seems impossible when nursing measures consist only of feeding, bathing and putting the patient to bed. What stimulus have I to pass on to my nurses? And is it to be wondered at that the nurses in the wards readily say 'There's nothing in it'?

"If a fracture occurs on the ward, or a case of typhoid fever develops, a clinic is held while the physician explains the symptoms, signs and treatment, and discusses the nursing measures which may be applied. Why should not the symptoms, signs and treatment of mental diseases be as freely discussed with the nurses?"

And why is it we find that so many nurses who have received valuable training in the care of mental patients are not following this branch of nursing? Why do we find them choosing work in tuberculosis wards, in chronic medical wards and other branches of general nursing? Their reply is that they are discouraged by the outlook, because they have to scramble and grope for knowledge, even to beg for it in order that they may minister at all efficiently to the needs of their patients. They all admit that though the work is hard, it is not too hard providing they could find satisfaction in it and opportunity for growth and development.

Proper Instruction Arouses Enthusiasm

In the training school of a large general hospital which has an active psychiatric department the nurses during their period of training are assigned to two months' service in this department. They are so enthusiastic about the work and find the mind is so much more interesting to study and nurse than the body that they invariably ask to have their period of service prolonged, and many elect to give a much longer period to post graduate study. In this hospital the nurses are given a very carefully prepared course of instruction in mental diseases, the principle and practice of mental nursing, occupational therapy, hydrotherapy, electrotherapy and mechanotherapy.

That there is a growing need and a more insistent demand for nurses who are trained in the care of mental diseases can no longer be overlooked or unheeded. Many schools of nursing are already providing courses of instruction in this subject, and while a short course of two or three months is not enough to prepare a nurse to specialize in any branch of psychiatric work, it will give her a knowledge which will help her better to understand and nurse all her patients, and will provide a basis upon which to build for future specialization.

Mental Hospital Is Best for Training

How then can this need for nurses trained in the care of mental diseases be met? Mental hospitals will always offer the best opportunities for this training, because all types of mental disorders are represented and all grades of symptoms may be noted. The patients in these hospitals are usually carefully classified, and these larger groups give a more outstanding picture of the various types. These hospitals should be able to offer excellent courses to nurses who wish to affiliate or to pursue post graduate study in psychiatry, occupational therapy, hydrotherapy, mechanotherapy, and the principles and practice of mental nursing, with adequate supervision on the wards by special instructors or teaching supervisors who would correlate the theory with the practical nursing. Clinics, too, should be held in which the physicians would demonstrate and explain the symptoms, signs and treatment of the various forms or types of mental disorder and disease, and outline and discuss the special nursing procedures which are applicable to each.

I believe that physicians who know the need must talk and preach and persuade the value of psychiatric nursing to training schools, to society and to the medical profession and must create the same enthusiasm for this branch of the healing art that an internist or surgeon inspires in his nurses. These nurses would in turn arouse the interest of other nurses both in and out of training. Superintendents of training schools and training schools committees would soon feel the enthusiasm and look to the subject with thought and not with reluctant obligation.

When schools of nursing are operated upon an educational basis, without hospital economics entering so largely into consideration, it will not be a question whether nurses can be "spared" to take duty in the psychopathic department or affiliated mental hospital, but it will be a question as to the maximum time that in fairness can be devoted to this subject.

1922 DEATH RATE IS HIGHER AND BIRTH RATE LOWER

The Department of Commerce announces that provisional mortality figures compiled by the bureau of the census for the first quarter of 1922 indicate higher death rates than for the corresponding quarter of 1921. For the states compared the death rate for the first quarter was 13.7 in 1922 against 12.6 for the first quarter of 1921. The highest mortality rate for the quarter is shown for the District of Columbia (17.6) and the lowest for Wyoming (9.6). These early figures forecast for the year 1922 a higher rate for the death registration area than the record low rate (11.7) for the year 1921.

Provisional birth figures compiled by the Bureau of the Census for the first quarter of 1922 indicate lower birth rates than for the corresponding quarter of 1921. For the states compared the total birth rate for the first quarter was 23.3 in 1922 against 25.3 in 1921. The highest birth rate for the quarter (29.2) is shown for North Carolina and the lowest (16.5) for the state of Washington. Higher rates will be necessary for the remaining months of the year if the 1922 rate is to equal the 1921 rate for the birth registration area—24.3.

NOT MODERN HOSPITAL PHOTOGRAPHER

Activities of an imposter, representing himself as an official photographer for THE MODERN HOSPITAL, still continue, and warning is again sounded to hospital executives not to grant any person entree to their institutions on the grounds that he is a representative of this magazine, unless he can furnish proper credentials.

Entrance into the Michael Reese Hospital of Chicago was sought recently by a J. H. Armstrong who presented the card of the American Reserve and Supply Co. of New York and declared that he was authorized to take some photographs for THE MODERN HOSPITAL. When the superintendent questioned the authenticity of his claim, he made a strenuous effort to secure the return of his card.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

A STUDY OF DIETETICS COURSES FOR PUPIL NURSES GIVEN IN CLASS "A" HOSPITALS*

BY HELEN CLARKE, M.S., COLUMBUS, OHIO.

THIS is a study of standards of dietetic instruction for pupil nurses. It is based on replies to questionnaires which were sent to all the hospitals in the United States and Canada, 422 in number, which in 1921 had been given the fullest approval of the American College of Surgeons. The list of approved hospitals was given in THE MODERN HOSPITAL, November, 1921, Vol. XVII, No. 5, pages 405-408. In order to present the questions exactly as they were used in making this survey, a copy of the questionnaire is quoted.

Replies were received by January 1, 1922, from 201, or 48 per cent, of the institutions. The questionnaires had been out a little more than a month. Of the replies 14 were from hospitals which have no training school and six were too indefinite to use. The 181 remaining questionnaires from 43 per cent of the hospitals questioned are the basis of the tables and discussions of this report.

The Questionnaire Sent Out

I. The instructor and methods of instruction in classroom work in dietetics.
  1. Is the instructor a graduate nurse?.....
  2. Is the instructor a graduate
    a. Of a two-year home economics course?.....
    b. Of a four-year home economics course?.....
    c. Of some other kind of course.....(Specify).....
  3. Does the instructor have other work in connection with the hospital, such as
    a. Purchasing food? .....
    b. Planning diets? .....
    c. Management of kitchen employes?.....
  4. Is the method used in teaching dietetics the lecture?..... The recitation?.....Recitation and lecture?.....
  5. In what year or years of the nurse's course is the dietetic classroom work taken?.....

II. Textbook.
  1. What textbook do you use in dietetics?.....
  2. Would the instructor prefer some other book?.....
    a. Because the one now used is too long?.....
    b. Too technical? .....
  3. Do you supplement the material in the textbook by using in lectures articles from current journals?.....

III. Laboratory work in dietetics.
  1. Is there laboratory work in connection with classroom work? .....
  2. In what year is it given?.....
  3. Do you use a laboratory provided for the purpose?.....
  4. Do you use a kitchen for the dietetics laboratory?.....
  5. What is done with the food prepared?.....
  6. What laboratory manual do you use as a guide for the work? .....
  7. Does the laboratory work include preparation of special diets? .....
  8. Do you give work in the preparation of formulas for infant feeding? .....
  9. Are menus for general standard diets prepared by the class? .....
  10. Do the nurses have opportunity to practice planning menus for their own table?.....
  11. Is any instruction given in purchasing food supplies?.....

IV. Practical work in the diet kitchen.
  1. In what year of the nurse's course does practical work in the diet kitchen come?.....
  2. How many weeks does it last?.....
  3. Is there a definite outline of the work to be done by the nurse while she is in the diet kitchen?.....
  4. Does the classroom work precede the diet kitchen work?....
  5. Who is in charge of the pupil nurse while in the diet kitchen? .....

V. General.
  1. Do you consider that the average nurse dislikes dietetics? .....
  2. If the nurse dislikes dietetics do you feel that it is because of
    a. Lack of preliminary work before entering the hospital? .....
    b. Lack of preliminary work after entering the hospital? .....

The hospitals returning usable questionnaires are classified by bed capacity in Table I.

TABLE I.

Number of Hospitals Studied, Listed by Bed Capacity.

Bed Capacity	Number Reporting
100-149	60
150-199	42
200-249	13
250-299	15
300-349	7
350-399	8
400-449	7
450-499	3
500-549	4
550-599	1
600-649	2
650-699	0
700-749	0
750-799	1
800-849	2
850-899	1
1000-2000	5
Total for United States	171
Total for Canada	10
Total usable questionnaires	181

The bed capacity of the hospitals was obtained from *The Journal of the American Medical Association*, Hospital Number, Volume 76, No. 16, April 16, 1921, pages 1087-1103, "Bed Capacity of General Hospitals and Daily Average in Constant Use During Preceding Year." Several hospitals not given in this list were found in the *American Medical Directory for 1921*.

Canadian hospitals are studied as one seperate group (1) to see if their method of dietetic instruction shows some striking contrast to the practice in the hospitals of the United States, (2) because the number is small to classify according to size, (3) because of the difficulty in obtaining accurate information as to bed capacity.

In the following report the questions are taken up

*A thesis presented by Miss Clarke to Ohio State University for the degree of Master of Science, 1922.

in the order in which they appear in the questionnaire. In the discussion reasons are sometimes given why a particular question was asked; second, the facts reported are stated; third, the facts are interpreted:

Question I. 1. Is the instructor a graduate nurse?

2. Is the instructor a graduate

a. Of a two year home economics course?

b. Of a four year home economics course?

c. Of some other kind of course? (Specify).

TABLE II.

General Training of Dietetics Instructors.

Graduate nurse	27
Two-year course, home economics	69
Three-year course, home economics	9
Four-year course, home economics	66
Graduate course, home economics	3
Course for student dietitian	21
College course other than home economics	4
Normal course	3
One-year academic course	8
Two-year academic course	2
Other courses not specified	28
	240

The training courses reported in Table II, total 240, which is 59 in excess of the number of hospitals, because some of the hospitals have more than one instructor and each instructor is included in these totals. Moreover, some instructors have graduated from more than one course. These instructors are counted in the tabulations for each separate course, because the reports are in such form that one cannot distinquish between the reports for two instructors and those for one instructor who has had two courses. Since some persons are reported twice in Table II it follows that the amount of training received by the instructors is greater than appears on the face of the report. Unpublished tabulations show no relation between the size of the hospital and the training of the dietitian.

It is found that of the twenty-seven nurses who are dietetics instructors, nineteen have had other courses besides those included in their nursing training. One of the instructors who has done graduate work has received a Ph.D. in nutrition from Yale. Further note is made in Table III of the hospitals where, as student dietitians, instructors received training.

TABLE III.

Hospitals Where Student Dietitians Were Trained.

Hospital—	Number of students trained
Massachusetts General Hospital, Boston	5
Peter Bent Brigham Hospital, Boston	1
Bellevue Hospital, New York City	1
Jefferson Hospital, Philadelphia	1
Johns Hopkins Hospital, Baltimore	1
St. Louis City Hospital	1
Lakeside Hospital, Cleveland	1
University of Minnesota Hospital, Minneapolis	1
San Francisco City Hospital	1
Indefinite as to hospital	8
	21

This extensive supervisory work has both advantages and disadvantages. The instructor who has a diversity of diets to plan and supervise has more valuable and interesting information pertaining to dietetics than one who does not plan diets or come into intimate contact with cases largely treated by dietetherapeutic means. On the other hand, the dietitian who is purchasing foods, planning diets and managing kitchen employes must have a primary interest in this and the teaching is almost necessarily given a place of secondary importance.

4. Is the method used in teaching dietetics the lecture? The recitation? Recitation and lecture?

These questions were to determine the extent to which the different methods prevail. Answers show that in nine, or 5 per cent of the schools the lecture method is used; in four, or 2 per cent, of the schools the recitation is used; while 168, or 93 per cent, use the combined lecture and recitation. Many schools have in addition class demonstrations in connection with these lectures and recitations.

5. In what year or years of the nurse's course is the dietetic classroom work taken?

This question was asked to find out whether there is any prevailing standard. The answers, together with other facts, appear in Table V.

Textbooks in Use

Question II. 1. What textbooks do you use in dietetics?

TABLE IV.

Textbook Used.

Name of Book—	Number of schools using book
Pattee—Practical Dietetics	82
Proudfit—Dietetics for Nurses	80
Friedenwald and Ruhräh—Dietetics for Nurses	9
Strouse and Perry—Food for the Sick	4
Farmer—Invalid Cookery	1
Rose—Feeding the Family	1
Pope—Practical Dietary Computer	1
Carter, Howe and Mason—Nutrition and Clinical Dietetics	1
Pope and Carpenter—Essentials of Dietetics	1
No book used	8

Seven schools are using more than one textbook in dietetics.

2. Would the instructor prefer some other book?

In some institutions the textbook for dietetics instruction is chosen by the superintendent of nurses or some one other than the dietitian who is connected with the training school. The book used may not suit the needs of the class as well as some other which the instructor may know and prefer. Replies show that 29, or 16 per cent, of the instructors prefer another book; 98, or 54 per cent, do not prefer some other; 54, or 30 per cent, do not report. Of those who desire to use another book, seven give as their reason that the book used is too long and six that it is too technical. Three say that the book used is too brief, one that the book used is incomplete, another that the book used is inaccurate and eleven give no reason for preferring some other book.

The American Dietetic Association is making an attempt to have better courses of training in dietetics in the hospitals as well as in the colleges. In a preliminary report of a committee working out courses for student nurses this comment is given about textbooks. "A good textbook and suitable reference books relieve students from much note-taking, but at present there appear to be few suitable books of this kind for student nurses. Some are, for the most part, a collection of recipes, while others pay too much attention to specific methods and specific information, with inadequate attention to general principles. The material presented is not always well adapted to the average general educational preparation of the class and to their vocational needs." This is quoted from THE MODERN HOSPITAL, Vol. XVIII, No. 3, March, 1922, p. 271, "The Teaching of Dietetics to Student Nurses."

3. Do you supplement the material in the textbook by using in lectures articles from current journals?

Hardly an issue of a journal of medicine or of the allied sciences fails to contain information relating to food and nutrition. The instructor may take advantage of these articles in giving new, accurate and interesting material to her classes. This is done in 140, or 77 per cent, of the hospitals. In 17, or 9 per cent, of the hospitals

the instructors say they do not supplement their lectures by current articles; 24, or 14 per cent, give no answer.

Laboratory Work in Dietetics

Question III. Laboratory work in dietetics.

1. Is there laboratory work in connection with classroom work?

2. In what year is it given?

The former question was asked to determine whether the theory is being strengthened by practice. There are 158, or 87 per cent, of the schools giving laboratory work; 16, or 9 per cent, do not give this work; 7, or 4 per cent, give no report.

TABLE V.

Year in Which Classroom and Laboratory Work is Given.

Year—	Classroom	Laboratory
1	41	72
2	20	29
3	14	11
1, 2	47	22
1, 3	18	7
1, 2, 3	17	7
2, 3	9	10
No report of year	15	0
Total	181	158

This table shows that there are twenty-three more schools giving classroom work than are giving laboratory work. Moreover, where both are given they are frequently not concurrent. In 49 cases classroom work is not accompanied by laboratory work in that year. In 41 cases there is laboratory work without classroom work in the same year.

3. Do you use a laboratory provided for the purpose?

4. Do you use a kitchen for the dietetics laboratory?

These questions were to determine whether a special arrangement is made so that the nurses have a suitable place for laboratory dietetics work. It is difficult to find a time when a hospital kitchen is free long enough to use as a class laboratory. It is also hard to find a kitchen which can be conveniently arranged for general work as well as be fitted with equipment for a class. It is, therefore, significant to see the number that use kitchens. It is found that 81, or 51 per cent, of the classes use a laboratory; 53, or 34 per cent, do not use a laboratory; 24, or 15 per cent, give no report. There are 110, or 70 per cent, of the classes which use a kitchen; 33, or 21 per cent, do not use a kitchen; 15, or 9 per cent, do not report. It is found that of these hospitals having laboratory work, 33, or 21 per cent, are using both a kitchen and a laboratory for the work.

5. What is done with the food prepared?

In 87, or 55 per cent of the classes the nurses eat the food they prepare; in 53, or 34 per cent of the schools the food is served to the patients; in 18, or 11 per cent of the schools the food is used by both the nurses and patients.

6. What laboratory manual do you use as a guide for the work?

TABLE VI.

Manual Used for Classes.

Manual—	Number of classes using manual
Rose—Laboratory Manual of Dietetics	27
Pattee—Laboratory Manual	16
Proudfit—Laboratory Manual	12
Manual prepared for use of hospital	10
Manual prepared by dietitian	8
Outline in the Standard Curriculum for Nurses Training Schools	4
Locke—Food Values	4
Stout Institute Manual	1
Bailey—Domestic Science, Principles and Application	1
Maxwell—Pope—Dietetics for Nurses	1
Farmer—Invalid Cookery	1
No manual used	29
No report given	44
Total number of schools giving laboratory work	158

7. Does the laboratory work include preparation of special diets?

The criticism is often made that nurses do not know what foods are permissible for nephritic or diabetic patients or what is meant by special diets for specific diseases. In 122, or 77 per cent of the laboratory classes work is given in preparation of special diets; 25, or 16 per cent of the classes do not give this work; 11, or 7 per cent of the classes do not report.

8. Do you give work in the preparation of formulas for infant feeding?

There seems to be a general tendency to give this work in some other department than that of dietetics. If the answer on the questionnaire indicates that the work is given in any department of the hospital the answer is included as an affirmative. There are 144, or 80 per cent of the hospitals which give this work; 25, or 14 per cent do not give this work; 12, or 6 per cent do not report.

9. Are menus for standard diets prepared by the class?

Usually each hospital has its list of permissible foods which may be included in so-called liquid, soft, light or general diets. It is necessary that a nurse know these foods and how to group them for meals. In preparing foods, planning menus and serving trays during her work in the diet kitchen it seems absolutely necessary that she be familiar with these diets. In 108, or 68 per cent of the laboratory classes menus for standard diets are prepared; 50, or 32 per cent do not give this work.

10. Do the nurses have opportunity to practice planning menus for their own table?

There are four distinct advantages in such practice: first, in planning such menus the nurses learn the dietary requirements for a normal, active group; second, they have to use nearly all the knowledge they may have gained in theoretical and practical dietetics; third, they learn that they have to consider such factors as cost of food, practicability for preparation and service in their institution. This work makes nurses less critical about their own food. Finally, whenever applicable, suggestions made by nurses in planning for their own table can be used by the dietitian in her menu planning. Reports show that 49, or 31 per cent of the laboratory classes practice planning menus for their own table; 109, or 69 per cent do not.

11. Is any instruction given in purchasing food supplies?

Reports show that 68, or 43 per cent of the laboratory classes have instruction in purchasing food while 90, or 57 per cent do not have this instruction.

Practical Work in Diet Kitchen

Question IV. 1. In what year of the nurse's course does practical work in the diet kitchen come?

2. How many weeks does it last?

Reports show that 168, or 93 per cent of the schools give this work; while 13, or 7 per cent do not have it. The years in which it is given and the length of the course are shown in Tables VII and VIII.

TABLE VII.

Year Course in Which Diet Kitchen Work is Given.

Year—	Number of hospitals
1	37
2	42
3	36
1, 2	15
1, 3	12
1, 2, 3	8
2, 3	18
Total courses	168

TABLE VIII.

Length of Course in Diet Kitchen Work.

Number of weeks	Number of hospitals
2	1
3	10
4	33
5	6
6	33
8	61
9	4
10	4
12	12
14	1
15	1
16	2
Total classes	168

The function of the training in the diet kitchen is expressed in the following quotations. "It is coming to be generally recognized that the diet kitchen is a laboratory where the student nurse may apply her technical knowledge and where she may develop a fair degree of skill in preparing food for the sick. The student is there to be taught and must not be thought of simply as a means of getting the work done. . . . Students should have some of their diet kitchen experience during their preparatory course or soon after. . . . This period should be for at least three or four weeks, the time of each student being carefully organized." The Modern Hospital, Vol. XVIII, No. 3, March, 1922, p. 271.

3. Is there a definite outline of the work to be done by the nurse while she is in the diet kitchen?

Some instructors say that the work is dependent upon the patients and their diets, others say there is a very definite outline. An outline is used by 158, or 94 per cent of the hospitals giving work in the diet kitchen; 10, or 6 per cent do not have an outline.

4. Does the classroom work precede the diet kitchen work?

The classroom work precedes or is concurrent with the diet kitchen work in 161, or 95 per cent of the hospitals, in 7, or 5 per cent, it follows the diet kitchen work.

5. Who is in charge of the pupil nurse while in the diet kitchen?

The dietitian is in charge in 156, or 93 per cent of the diet kitchens, a graduate nurse is in charge in 10, or 6 per cent. No answer is given by 2, or 1 per cent of these hospitals having diet kitchen work.

Attitude of Nurses Toward Subject

Question V. 1. Do you consider that the average nurse dislikes dietetics?

2. If the nurse dislikes dietetics do you feel that it is because of

a. Lack of preliminary work before entering the hospital?

b. Lack of preliminary work after entering the hospital?

Reports indicate that 57, or 31 per cent, of the instructors consider that the average nurse dislikes dietetics; 111, or 61 per cent, do not believe this and 13, or 8 per cent give no answer. There are 66, or 36 per cent who believe the dislike is caused by lack of preliminary work before entering the hospital. These instructors feel that many nurses lack a knowledge of chemistry. Preliminary work before entering the hospital is not believed to be the cause by five, or 3 per cent; 110, or 61 per cent give no answer. There are 19, or 10 per cent who believe a dislike is caused by preliminary work after entering the hospital; 16, or 9 per cent do not believe this the reason; and 146, or 81 per cent give no reply.

The questions concerning the true or apparent dislike of dietetics by the average nurse evoked more comments by the instructors than did any of the other questions. In classifying criticisms six main reasons are distinguished, as follows: (1) Lack of application on part of the nurse. This may be partially explained by the fact that the pupil nurses are required to do much uninteresting routine work in the diet kitchen. (2) Lack of interest in the subject. Because of their unfamiliarity with dietetics, nurses fail to realize the importance of the subject and the relation which it bears to nursing. (3) Prejudice is a factor in the dislike of dietetics for many times nurses dislike cooking and they fail to see the broader meaning of dietetics. Many instructors trace the dislike of the subject to the fact that the nurse dislikes any work connected with a kitchen. (4) Lack of time for study of the subject. In some schools it is believed that the dislike of dietetics is caused by crowding a heavy subject into a short space of time. (5) The attitude of the hospital toward the subject. A few instructors still cling to the belief that the subject is not sufficiently supported by the faculty of the training school but realize that this feeling is rapidly disappearing. (6) Factors relating to the instructor and her methods of teaching. The presentation of the subject must be interesting, the work must be correlated with the needs of actual patients and it must not be too technical. Some instructors feel that the previous training of the nurses has little influence if a clear, forceful method of teaching dietetics is followed.

Conclusions

The answers and tables give the data obtained from the answers to the questionnaires, but various inductions may be made from the study of them as a whole.

1. The hospitals do not have a minimum standard of educational requirements for dietitians. Comparatively few instructors have had courses as student dietitians.

2. So far as the answers to the questions indicate the duties of the instructors are nearly uniform in each hospital.

3. The methods of instruction are very similar in all hospitals.

4. There are no definite years when classroom or laboratory work are given and these classes are often not concurrent. Classroom work usually precedes that given in the diet kitchen.

5. Most of the schools use a textbook for class instruction in dietetics. Fewer use a laboratory manual. An outline for the diet kitchen work is generally used.

6. The opportunity for giving work in the laboratory in preparing special diets, infant formulas, preparing diet lists, making menus and purchasing food supplies is not used to the extent which is easily possible by the laboratory classes.

7. Practically one-third of the instructors feel that the average nurse dislikes dietetics. The comments which are given may serve as very helpful constructive criticism.

Smile into the face of the world and a smile comes back; render a good service to others and good service is returned to you; show a spirit of helpfulness and that spirit will surely send back aid to you of a like kind; think good thoughts and the same good thoughts will be thought of you. The world is a great mirror which truly reflects the thoughts, acts and ambitions of every individual. Let no one cloud his vision, poison his mind and dwarf his soul with false imagination that the world is not giving him a square deal. The only way to avoid getting a square deal from the world is by not giving the world a square deal yourself.

HOW MANY TEASPOONS IN A ONE POUND CAN OF BAKING POWDER?*

IN AN effort to answer the oft asked questions: "Can you depend upon so-called measuring spoons for accurate results?" "Can you depend on them more than you can the ordinary type of teaspoon?" a considerable number of experiments were performed. We tried to get as many kinds of spoons as possible and found six different brands, all of which showed more or less variation as to capacity. Of the fourteen teaspoons tested, eight were of the aluminum sets containing one tablespoon, one teaspoon, one-half teaspoon and one-quarter teaspoon, linked together. These are commonly used in the home kitchen for measuring.

The volume of these spoons was determined by dipping the spoon into very fine sifted sand, leveling with the edge of a spatula and measuring that sand in a 10 cc. graduate. Sand was chosen for determing the volume because it would not pack on dropping from the spoon to the bottom of the graduate as much as baking powder would. All the measuring was done by one person in an effort to eliminate the personal element.

TABLE 1—VOLUME OF TEASPOONS USED FOR MEASURING

Number of Spoon	Volume	Variation from Theoretical as given by Bureau of Standards* (5 cc.)
1	4.3 cc. 4.3	-0.7 cc
2	5.2 5.12	0.17
3	4.9 4.9	-0.1
4	4.8 4.85	-0.17
5	4.9 4.9	-0.1
6	4.7 4.7	-0.3
7	4.5 4.45	-0.5
8	4.9 4.9	-0.1
9	4.85 4.9	-0.12
10	5.0 4.95	0.00
11	4.9 4.9	-0.1
12	4.6 4.6	-0.4
13	4.9 4.92	-0.09
14	4.85 4.85	-0.15

*Circular of the Bureau of Standards No. 55, Measurements for the Household.

The average volume of a teaspoon from the twenty-eight samples measured was 4.8 cc.

The only variations which can be considered at all significant are those of teaspoons No. 1, No. 7, and possibly No. 12.

If we allow a variation of 10 per cent (.5 cc) above and below the standard we should have a variation of from 125 to 150 teaspoons in the one pound can of baking powder. These measurements assume an average weight of 3.3 grams for a 5 cc. teaspoon, levelful. (See Table 2 below).

TABLE 2—WEIGHT OF ONE MEASURING TEASPOON OF BAKING POWDER
(Teaspoon No. 10 of Table 1)

Number of Sample	Name	Date of Manufacture	Measured by A. P. Warren Weighed by Dr. Patten			
1	Bob White	July, 1919	3.480 g.	3.285 g.	3.370	3.376 g.
2	Crescent	June, 1919	3.385	3.260	3.405	3.350
3	Royal	Unknown	2.790	3.035	2.975	2.933
4	Ryzon	Unknown	2.935	2.875	2.735	2.848
5	Rumford Yeast P.	Unknown	3.725	3.595	3.685	3.668
6	Rumford	July. 1919	4.150	4.145	4.380	4.225
Samples supplied to, or purchased for the experimental kitchen.						
1	Rumford	Unknown	3.955	3.815	3.710	3.823
2	Ryzon	Unknown	Cake—Discarded			
3	Bob White	Unknown	2.920	2.725	2.820	2.831
4	K. C.	Unknown	3.070	2.905	2.735	2.903
5	Calumet*	Unknown	4.060	3.905	3.810	3.925
6	Davis	Unknown	3.595	3.455	3.505	3.518
7	Calumet*	Unknown	....	3.740	3.700	3.720

Samples supplied by Bureau of Chemistry.
*Sample No. 5 of Calumet Baking Powder was measured in measuring spoon No. 10, which conforms to the Bureau of Standards Theoretical method. Sample No. 7 of the same baking powder was measured in William Rogers teaspoon.

The teaspoon of set No. 10 was used in Table 2, which shows the weight of one teaspoon. It will be observed that this was the only one of the fourteen which conformed precisely to the volume given by the Bureau of Standards (5 cc.).

Samples No. 5 and 7 of baking powder furnished by the Bureau of Chemistry illustrate the difference between measurements taken with the special spoon sold as a measuring spoon (Sample No. 5) and those taken with an ordinary teaspoon (Sample No. 7).

The samples were obtained by dipping the spoon into the can of baking powder, leveling with the edge of a spatula, and emptying into balanced watch glass on analytic as scale.

The measurements were all made by myself and all weighed by Dr. Patten of the Bureau of Chemistry. They all check fairly closely when taken on the same sample.

From the above data the average of those weighed on analytical balance (48 weighings, 12 samples, 8 brands) equals 3.3 grams (whether taken as the average of all the samples, or as the average of all averages for each brand). The variations seem to be as great among different samples of each brand, as among different brands.

A number of tests were made to determine the effect of personal equation, in manipulation, upon the amount of baking powder measured as one "standard" level teaspoon. Four trained laboratory workers took measurements on each of twelve samples of baking powder representing eight brands. These measurements were then weighed (though not on analytical balance), as were the amounts measured by myself. The differences due to per cent of the smallest amount measured, except in case of one sample where the range was 30 per cent. The variations due to manipulation of different persons with the same teaspoon are more numerous and greater than individual manipulation ranged from 10 per cent to 20 the variations due to differing capacities of different teaspoons.

*From Experimental Kitchen, Office of Home Economics, States Relations Service, U. S. Department of Agriculture, Washington, D. C.

Do three teaspoonfuls make one tablespoonful?

The statement that three teaspoonfuls make one tablespoonful is accurate enough for many practical purposes. But what is the range of variation as measured by careful weighing?

It might be supposed that in the manufacture of the aluminum sets sold for household measuring purposes, one would find conformity to the theoretical relation between the teaspoon and tablespoon; but the figures obtained below do not seem to substantiate that relationship.

For this comparison set No. 6, which consists of one tablespoon, one teaspoon, one-half teaspoon and one-fourth teaspoon made of aluminum and linked together, was used.

TABLE 3

Tablespoon from set No. 6—16.66 cc., or 3.54 times teaspoon No. 6.
One-half teaspoon from set No. 6—2.53 cc., or 0.57 times teaspoon No. 6 (instead of 0.5).
One-fourth teaspoon from set No. 6—1.15 cc., or 0.244 times teaspoon No. 6 (instead of 0.25).

Conclusions:

1. The weight of one teaspoonful of baking powder may be taken as 3.3 g. so far as these experiments are concerned.

2. It cannot be said that any one of these brands of powder gives a heavier or lighter teaspoonful than any other; but only that all brands vary a good deal among their different samples.

3. Teaspoons vary a little in size, occasionally. More important, however, are the variations in their manipulation by different persons, such as depth to which the spoon is dipped, manner of leveling, etc.

ARMY MEDICAL DEPARTMENT STUDIES SOURCES OF SUPPLIES

As part of a comprehensive study under the direction of the assistant secretary of war, the medical department of the army is undertaking a study of the sources from which the supplies which it procures and uses can be had. The medical department is not only concerned with the provision of the personnel necessary to the treatment of the sick, but is also charged with the supply of those things which are required by such personnel.

The armamentarium of modern medicine is exceedingly intricate, but without it the wonderful advances made in medicine are not available to the sick and injured, however skillful the personnel. The difficulties encountered in providing such elaborate equipment in time of war for the large number of new hospitals, infirmaries and first aid stations necessary, and particularly in providing it at those institutions in the advance area are manifest, and yet if the soldier is to be given the service to which he is entitled it must be provided.

In war of any magnitude the burden thrown upon industry for the production of these supplies is enormous. Any information that could be made available beforehand to industry as to type, number and quality, would obviously be of great advantage to industry in its plans. The surgeon general is therefore side by side with his plans for extension of the Officers' Reserve Corps and with his plans for instructing medical students through the R.O.T.C. in those duties of a medical officer which differ from those of the civilian physician, determining where the supplies needed by these officers may be had, should any grave emergency arise.

This effort is an attempt to do beforehand what was necessary after the declaration of war in the recent World War. It is done in recognition of the fact that the forces of the medical department, however numerous and skillful they may be, will be but half prepared without the necessary equipment. In brief, the program contemplates (1) that a careful determination shall be made, not only of the items needed, but of the quantity thereof. With a close liason established with industry, it is probable that often final decision as to the type of an article selected will be determined by the facilities of industry to produce it in large quantity. (2) The plan also contemplates a roster of personnel skilled in the manufacture, inspection and purchasing of the various commodity groups. It is desired to secure from industry itself, men who are eligible and will accept Reserve Corps commissions with a view to their assignment in time of emergency to the procurement of the commodity in which they are specialists. It is proposed that upon these men reliance will be placed in time of peace for advice and assistance in the study of industrial facilities and that in time of war they will be assigned to the centers of industry or to Washington for procurement duty. (3) The plan further contemplates that a thorough study be made of the facilities of the country to produce the essential and important items of the supply table and to have on file in the office of the surgeon general such reports as will enable the immediate placing of contracts in the event of any national emergency.

In this work the surgeon general realizes that he must rely upon industry itself, and it is hoped to secure definite and complete information from the manufacturers as to aid they can render. It is probable that in an emergency of any magnitude, Congress would again establish control of raw materials, labor, transportation and installations and the Medical Department expects that with the information to be obtained from the study on file, it will be in a position to render great assistance to the firms making medical department supplies. It can prevent the drafting of skilled labor, the taking of key men, it can assure the supply of material, of coal and of transportation and thus obviate difficulties in the operation of the plant.

"Let me do my work each day; and if the darkened hours of despair overcome me, may I not forget the strength that comforted me in the desolation of other times. May I still remember the bright hours that found me walking over the silent hills of my childhood, or dreaming on the margin of the quiet river, when a light glowed within me, and I promised my early God to have courage amid the tempests of the changing years. Spare me from bitterness and the sharp passions of unguarded moments. May I not forget that poverty and riches are of the spirit. Though the world know me not, may my thoughts and actions be such as shall keep me friendly with myself. Lift my eyes from the earth and let me not forget the uses of the stars. Forbid that I should judge others, lest I condemn myself. Let me not follow the clamor of the world, but walk calmly in my path. Give me a few friends who will love me for what I am; and keep ever burning before my vagrant steps the kindly light of hope. And though age and infirmity overtake me, and I come not within sight of the castle of my dreams, teach me still to be thankful for life and for times' olden memories that are good and sweet; and may the evening's twilight find me gentle still."—Max Ehrmann.

"Those who undertake such work (as nursing) must be not sentimental enthusiasts, but downright lovers of hard work."

OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by HERBERT J. HALL, M.D., President, American Occupational Therapy Association, Devereux Mansion, Marblehead, Mass., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
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SOME FALLACIES ABOUT THE REHABILITATION OF THE DISABLED SOLDIER

BY HERBERT J. HALL, M.D., PRESIDENT, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, MARBLEHEAD, MASS.

IN AN article published some time ago in the *Washington Post*, Brig. Gen. Charles E. Sawyer, physician to the President, outlines a "Hospitalization Ideal" and writes convincingly of a plan of centralization whereby in three or four large colonies he would have the disabled war veterans receive their medical treatment and an education which would fit them for actual service in the industrial world. He would remove the stigma of the asylum and the tuberculous sanatorium by having little or no separation of the insane, or the tuberculous, from the others and he would accompany medical treatment with vocational and academic training. He would have the men under treatment bring their families and build their own homes within the reservations; he would have agriculture and the trades taught practically and on the spot.

Favors Rehabilitation Centers

General Sawyer sees great evil in the specialized institutions scattered all over the country. His plan certainly has much to recommend it, however great might be the cost of scrapping the existing hospitals. There are to be sure certain serious objections, perhaps the most cogent being that so far large colonization schemes have been something of a failure. Men prefer to live in their own localities and do not take kindly to centralization. A complete separation of the really insane from the sane will surely be found necessary. An absolute isolation of the actively tuberculous is almost as desirable as the segregation of such communicable diseases as diphtheria and scarlet fever. However, it would be a wonderful thing for the soldier to go simply to a rehabilitation center and not to an asylum or a sanatorium; there is no denying that.

General Sawyer declared in his article: "To make such a plan workable it is quite important that every institution giving hospital care to the former soldier should have a well equipped and perfectly arranged special department in which vocational training can be carried on with an academic course as the underlying principle. It will then be quite easy to carry out a commercial course which would lead into all the practical lines of business affairs such as banking, accounting, etc. There should also be an industrial branch of the educational system which would give to every individual the opportunity to improve himself in any of the industries, such as carpentry, masonry, architecture, machine construction, machinery operation, etc."

Many Men Unfitted for Business

It is conceivable that a great centralization would produce better results in this direction that is now being accomplished in government hospitals all over the country. There is some doubt of this however. The fact is that a very large number of the disabled soldiers do not succeed very well in the study of business affairs, banking, accounting, and the like. There is a reason, and if they do not succeed in the smaller institutions why should they in proposed larger ones?

In one of the military hospitals during the war a course in stenography was advertised to begin on a certain date. A surprising number of applications were made for this course, fifty or more. When the class assembled, it was found that only a half dozen could read or write correct English. I am not "knocking" the American soldiers, far from it; they are a fine lot and worthy of every educational advantage we can give them, but we can hardly make bankers and architects out of them. It is said[1] that 1,700,000 drafted men were given psychological tests, and that seventy per cent of them showed an intelligence age of fifteen years. Forty-five per cent of the total number were morons, and of so low an intellectual capacity as not to be capable of self guidance. What does this mean? Only that the reëducation of the disabled soldier with few exceptions can be of a very elementary character only. Does it seem altogether wise to establish universities, or even elaborate business courses, for men who will never be able to progress beyond the grammar school grades?

There can be no doubt at all of the value and wisdom of careful training in the common school branches and the trades such as carpentry, electrical practice, masonry, blacksmithing, etc. This work is being done pretty well already in the existing government hospitals. It can be done much better as time goes on and with the equipment already at hand.

The proposed new system has little use for the diversional and curative occupations which have been so popular in the military hospitals during and since the war. General Sawyer's article goes on to say:

[1] Memoirs of National Academy of Sciences, Vol. xv., p. 99, Psychological Examining in U. S. Army. Edited by Robert M. Yerkes, Government Printing Office, 1921.

"A vocational training program which is carried out on a basis of entertainment and hospital occupation is unfair both to the world war veteran and to those who have the responsibility of operating such an institution. Bead and basket work and similar occupations have a place but certainly are not entitled to more than passing consideration in the attempt to rehabilitate soldiers" . . . . . "Let us study and work to make our boys strong and capable rather than effeminate and indifferent. Let us give them punch and determination rather than dependence and lack of character."

Now here lies, in the opinion of a good many whose views are worthy of respect, a very serious misapprehension which should not go unchallenged. Beyond the shadow of a doubt, we should give our disabled soldiers punch and determination rather than dependence and lack of character. But punch does not come to the slowly convalescent and the badly crippled man except by a very gradual process. The effeminate occupations, the bead work and the basketry referred to, have been of the very utmost service. A disabled man must walk before he can run, sometimes he must creep before he walks. It is also true that we may lead sometimes when we may not force or demand. The simple peasant crafts of hand weaving, toy making, basketry and the like will often appeal to the weakened convalescent when the heavier more exacting work of true vocational training seems, and is, wholly out of reach. It is the object of the so-called occupational therapy to interest the patient in some kind of objective work which is within his narrowed compass. Those who have had experience in this field know that such small occupations serve to strengthen and develop the weakened will, that they prepare the way for vocational training, for academic progress, or for any kind of independent life. It happens that a young women teacher trained in the art of occupational therapy and armed with diversional and developmental crafts work not infrequently gets at the good side of a man and "starts him going" when masculine authority, official though it may be, fails miserably.

It will not do to assume that the tuberculous, for instance, can during early convalescence undertake the same vigorous and constructive activities that are safe and proper for the constitutionally sound convalescent from gunshot wounds. Nothing but unwarrantable risk can accompany an attempt to force the issue. Even death is a possible result of too vigorous effort on the part of the consumptive patient. But no one doubts the value of light occupations such as basketry and bead work for such people. The occupational instructor, let it be repeated, often gets nearer than the doctor or the nurse to the heart of the convalescent, and is in a position through the practical help he gives, to save many a wrecked morale.

The hospital visitor has perhaps seen some husky exdoughboy stringing beads and has said, "This is absurd, such a man should be doing something worth while, he should be preparing himself for real real work in the world; enough of this foolishness." Well, the surgeons in the base hospitals in France said and thought the same thing until they came to realize that these "foolish occupations" changed the wards from serious demoralization to hopefulness and order. By all means, graduate as soon as possible to the more manly and vigorous vocational training, but let us be sure first that the patient *can* so change and let us not minimize the importance of the thin wedge that opens the way. Is it surprising that the amusing occupation of basketry, toy making and the like should have a real place in the development and progression of men who possess to begin with only the intellect and capacity of children?

We may not without danger to the success of the whole system of rehabilitation throw aside or ignore these wholesome, developmental crafts. If we are to have established new reconstruction centers, they should be strong in the small arts which stimulate interest and develop ability to sustain effort of any kind and so make possible the higher grades of reeducation.

The nation has an unprecedented chance to reeducate and to improve the industrial and intellectual possibilities of sick and disabled soldiers. There is no more appealing or more practical service. Money spent for such purposes, however great the amount, could find no better moral or economic use. But may it not be wise to pause and consider well before we discard our entire military hospital system? Perhaps after all, the old shears may be made to cut. Perhaps the old service may be quickened and developed to a point of full efficiency.

Brig. Gen. Sawyer, the president's physician, wants the disabled ex-service man given "punch and determination," which characteristics in his opinion are not developed by bead and basket work. The brigadier general is quoted as saying that the small arts are not entitled to more than passing consideration in the attempt to rehabilitate soldiers and that their tendency is to foster a dependent and effeminate spirit among the men.

In the accompanying article, Dr. Herbert J. Hall points out what seems to him the essential and rightful place of the arts and crafts in rehabilitating the former soldier. Not only have intelligence ratings disclosed that the average ex-service man is mentally unfitted for the skilled and professional studies General Sawyer would have him undertake, but his physical condition is frequently such that immediate application to strenuous study would be harmful and even fatal, Dr. Hall believes. As a stepping stone to vocational training, not to mention its value in maintaining the former soldier's morale, Dr. Hall sees justification and need for occupational therapy work in government reconstruction hospitals.

STATE APPOINTS O. T. FIELD WORKER

The department of public welfare of Pennsylvania has taken a most progressive step in appointing a field representative in occupational therapy. The following announcement is made of the appointment:

"Recognizing the importance of occupational therapy in hospitals for mental diseases, the bureau of mental health of the Pennsylvania department of public welfare has established the position of field representative in occupational therapy. Miss Mary L. Putman, who has had experience in numerous states and institutions of various kinds has been appointed to this position. Several mental hospitals in Pennsylvania have very excellent occupational activities going on and it is expected that through Miss Putman's efforts, such facilities will be extended throughout the state. Miss Putman will first conduct a survey of

Adv. page 50

the various institutions as to the scope of their occupational activities. She will also be available for consultation and organization of occupational activities in the various other institutions under the supervision of the department of public welfare."

Miss Putman has been in the work a long time and has many friends throughout the country who are rejoicing in this recognition of her splendid understanding of mental patients and are appreciating the new lines of service which are open to her ministrations.—E. U. D.

THE ROLL CALL

Institutions Having Occupational Therapy

ILLINOIS.

Chicago Tuberculosis Sanitarium.
Chicago State Hospital.
Children's Memorial Hospital.
Cook County Hospital.
Cook County Psychopathic Hospital.
Home for Destitute Crippled Children.
Michael Reese Hospital.
Presbyterian Hospital.
St. Luke's Hospital.
U. S. Marine Hospital No. 5.
U. S. Veterans Hospital No. 30.
U. S. Veterans Hospital No. 30 Annex.
U. S. Veterans Hospital No. 76.
Wesley Memorial Hospital.
Improvement Association for Blind People.
The Spaulding School.
The Vocational Society for Shut-Ins has occupational therapy centers. A number of private hospitals, public institutions and state insane hospitals also have occupational therapy.

MANITOBA.

Winnipeg.
Manitoba Military Hospital.
Psychopathic Hospital.
Military Wing of General Hospital.
Military Wing of St. Boniface Hospital.
Deer Lodge Convalescent Home.

Selkirk.
Mental Hospital.

Brandon.
Mental Hospital.

Ninette.
Manitoba Sanatorium.

Portage la Prairie.
School for Feeble-Minded.

MARYLAND.

Sheppard & Enoch Pratt Hospital, Towson.
Phipps Psychiatric Clinic, Care of Johns Hopkins Hospital, Baltimore.
Spring Grove State Hospital, Catonsville.
Springfield State Hospital, Sykesville.
Crownsville State Hospital for Colored Insane, Crownsville.
Rosewood Training School, Owings Mills.
Dr. Barker's Nursing Homes, Baltimore.
University of Maryland Hospital, Baltimore.
Union Memorial Hospital, Baltimore.
Johns Hopkins Hospital, Baltimore.

MASSACHUSETTS.

General Hospitals.
Massachusetts General.
U. S. Marine No. 2.
U. S. Veteran's Hospital No. 36
U. S. Naval Hospital, Chelsea.
Children's Island Sanitarium.
Union Hospital, Fall River.
Beverly Hospital, Beverly.
Memorial Hospital, Worcester.

Tuberculosis Hospitals.
Boston Sanatorium.
Bay View, Fall River.
Plymouth County Hospital.
Tuberculosis Hospital, Pittsfield.

Mental Hospitals.
Boston Psychopathic Hospital.
Medfield State Hospital.
Boston State Hospital.
Northampton State.
Worcester State.
Gardner State Colony.
Grafton State.
U. S. Veteran's Hospital No. 44.
McLean Hospital, Waverly.
Channing Sanitarium.
Adams Nervine.
Woodside Cottages.
Glenside Hospital.
Devereux Mansion.
Dr. Rigg's Sanitarium, Stockbridge.

MICHIGAN.

Detroit Tuberculosis Sanatorium, Detroit.
Receiving Hospital, Detroit.
Ex-Service Men's Dept. Detroit T.B. Sanatorium, Detroit (Red Cross.)
U. S. Marine Hospital, Detroit.
Grace Hospital, Detroit.
Michigan Mutual Hospital, Detroit.
Herman Kieffer Hospital, Detroit (temporarily discontinued).
Children's Free Hospital, Detroit. (This work has been done through Red Cross and is volunteer work).
Detention House Juvenile Court, Detroit.
House Correction, Detroit.
Homeopathic Hospital, Ann Arbor.
Psychopathic Hospital, Ann Arbor.
Kalamazoo State Hospital, Kalamazoo.
Wayne County Insane Asylum, Eloise.
Battle Creek Sanitarium, Battle Creek.
Michigan School for Crippled Children, Farmington.
Eight departments for blind under Board of Education, Detroit.

MISSOURI.

Junior League Workshop, Barnes Hospital (for Washington University Dispensary Out-patients), St. Louis.
Barnes Hospital (Ward work conducted by Missouri Ass't for Occupational Therapy), St. Louis.
St. Louis City Hospital, St. Louis.
St. Louis City Sanitarium, St. Louis.
St. Louis Children's Hospital, St. Louis.
U. S. Marine Hospital, St. Louis.
U. S. Veterans' Hospital No. 35, St. Louis.
M.A.O.T. Shop for Handicapped, St. Louis.

Adv. page 32

Red Cross Workshop, Jefferson Barracks.
Robert Koch Hospital, Koch.
Jewish Sanitarium, Anglum.
Missouri State Sanatorium, Mt. Vernon.
State Hospital No. 1, Fulton.
State Hospital No. 4, Farmington.
Home for Aged and Infirm Israelites, St. Louis.
Mt. St. Rose Hospital, St. Louis.
State Hospital No. 2, St. Joseph.
State Hospital No. 3, Nevada.

NEW YORK.

Montefiore Hospital (Chronic).
Montefiori County Sanitarium.
11 county sanatoriums.
Bellevue General Hospital.
Sea View Hospital (Tuberculosis).
Randall's Island—Children (F. W.).
Hudson Hospital.
Neurological Hospital.
Vanderbilt Clinic.
Reconstruction Hospital.
St. Luke's Hospital.
Presbyterian Hospital.
Bloomingdale Hospital (mental—private).
5 private mental sanitariums.
Veterans Bureau Hospitals.
Trudeau Sanatorium.
4 private sanatoriums.

State Hospitals.

Brooklyn State Hospital, Brooklyn.
Buffalo State Hospital, Buffalo.
Central Islip State Hospital, Central Islip.
Gowanda State Homeopathic Hospital, Collins.
Hudson River State Hospital, Poughkeepsie.
Kings Park State Hospital, Kings Park.
Manhattan State Hospital, Ward's Island, New York City.
Middletown State Homeopathic Hospital, Middletown.
Rochester State Hospital, Rochester.
St. Lawrence State Hospital, Ogdensburg.
Utica State Hospital, Utica.
Willard State Hospital, Willard.

ONTARIO.

Christie Street Hospital, Toronto, Dept. of Soldiers' Civil Re-Establishment.
Euclid Hall Hospital, Toronto, Dept. of Soldiers' Civil Re-Establishment.
Brant Hospital, Burlington, Dept. of Soldiers' Civil Re-Establishment.
Mountain Sanatorium, Hamilton, Dept. of Soldiers' Civil Re-Establishment.
Muskoka Cottage Sanatorium, Gravenhurst, Dept. of Soldiers' Civil Re-Establishment.
Calydor Sanatorium, Dept. of Soldiers' Civil Re-Establishment.
Social Service Dept. Toronto & Hamilton, Dept. of Soldiers' Civil Re-Establishment.
Westminster Psychopathic Hospital, London, Dept. of Soldiers' Civil Re-Establishment.
Byron Sanatorium, London, Dept. of Soldiers' Civil Re-Establishment.
Sydenham Hospital, Kingston, Dept. of Soldiers' Civil Re-Establishment.
Mowal Sanatorium, Kingston, Dept. of Soldiers' Civil Re-Establishment.
Toronto General Hospital.
Toronto Free Hospital for Consumptives.
Industrial Home for Girls, Toronto.
Homewood Sanatorium, Guilph.
Hamilton General Hospital.
Ontario Hospital for Mental Diseases, Toronto.
Ontario Hospital for Mental Diseases, Hamilton.
Ontario Hospital for Mental Diseases, Whitby.
Rockwood Asylum, Kingston.

PENNSYLVANIA.

Philadelphia.

Philadelphia General Hospital.
Philadelphia Hospital for Mental Diseases.
Pennsylvania Hospital.
Pennsylvania Hospital, Department for Mental and Nervous Diseases.
University Hospital.
Jewish Hospital.
Friends' Hospital.
Children's Hospital.
Jefferson Hospital (Children).
Jefferson Hospital (Convalescent Home for Men).
The Browns' Farm (Orthopedic).
Phipp's Institute.
Home for Incurables.
Visiting Nurse Society.
American Red Cross (Navy Yard).
Public Health Hospital No. 49.

State.

Allentown State Homeopathic Hospital.
Pennsylvania State Sanatoriums at Hamburg, Cresson, and Mont Alto.
Harrisburg State Hospital, Harrisburg, Pa.

WASHINGTON, D. C.

Walter Reed Hospital, U. S. A. General Hospital.
St. Elizabeth's Government Hospital for the Insane.
McAlto Veterans' Bureau.
Tuberculosis Hospital.
Public Health Service, U. S.

WISCONSIN.

General Hospitals.

Columbia Hospital, Milwaukee.
Milwaukee Children's Hospital.
Mt. Sinai Hospital, Milwaukee.
Bradley Memorial Hospital, Madison.

Psychiatric Institutions.

The Milwaukee Sanitarium, Wauwatosa.
Milwaukee County Hospital for Mental Diseases.
Oconomowoc Health Resort, Oconomowoc.
U. S. Public Health Service Hospital No. 37 (Resthaven), Waukesha.
Wisconsin Psychiatric Institute, Mendota.
Riverside Sanitarium, Milwaukee.

Tuberculosis Sanatoriums.

Muirdale Sanatorium, Wauwatosa.
Statesan Sanatorium, Statesan.
Mt. Washington Sanatorium, Eau Claire.
Oaks Sanatorium, Pawaukee.
Maple Crest Sanatorium, Whitelaw.
Mount View Sanatorium, Wausau.
Riverview Sanatorium, Little Chute.
Sunny View, Winnebago.
River Pines, Stevens Point.
Hickory Grove, West De Pere.
Sunny Rest, Racine.
Willow Brook, Kenosha.
Pureair, Bayfield.
Oak Forest, La Crosse.

Adv. page 54

Pillsbury's Wheat Cereal

AS you know, there is no finer body-building food than farina, the rich, meaty heart of the wheat. Pillsbury's Wheat Cereal is pure farina, and because it comes from scientifically selected wheat, cleanly and carefully milled, it is of unusually high quality.

Every step in its preparation, from selection of wheat to packing in air-tight containers, is controlled by the Pillsbury Flour Mills Company and must measure up to Pillsbury standards. Throughout the entire process of milling and packing it is never touched by human hands.

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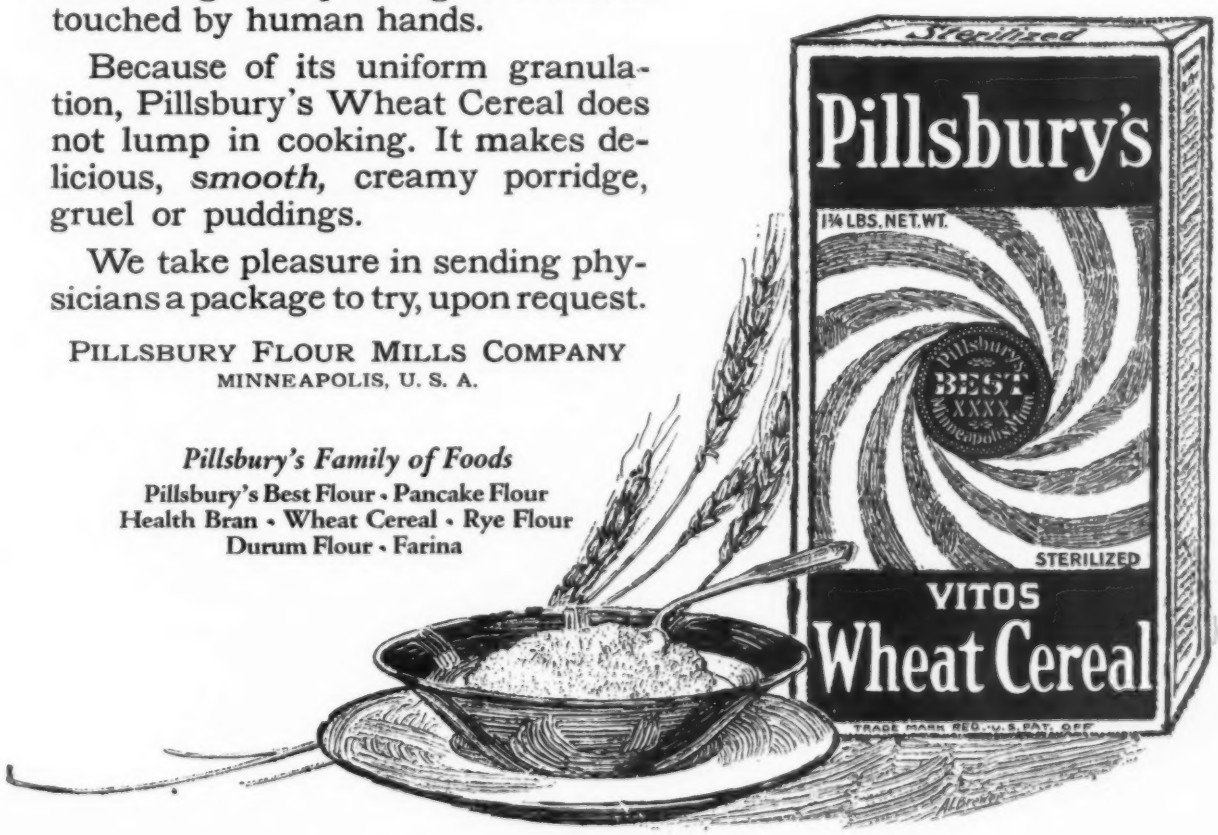

DISPENSARIES AND OUT-PATIENT DEPARTMENTS

Conducted by MICHAEL M. DAVIS, JR., Ph.D., Executive Secretary Committee on Dispensary Development, United Hospital Fund of New York, and Chief, Service Bureau on Dispensaries and Community Relations of Hospitals, American Hospital Association, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Director of Medical Activities, American Social Hygiene Association 370 Seventh Avenue, New York

SURVEY SHOWS NEED FOR FOLLOW-UP WORK IN EYE CLINICS

(FROM THE ASSOCIATED OUT-PATIENT CLINICS OF THE CITY OF NEW YORK.)

A COMMITTEE of leading ophthalmologists of the city of New York, organized as the ophthalmological section of the Associated Out-Patient Clinics, has instituted a number of studies of eye clinics, with a view to ascertaining present conditions and developing desirable standards. Some material on the timely and important subject of follow-up seemed worthy of publication in advance of the complete report and findings of the section.

Dr. Walter E. Lambert is chairman of the committee, and Dr. Conrad Behrens Jr., secretary. The study was made under the supervision of the committee by Dr. Gertrude E. Sturges and Miss Elizabeth Tandy of the staff of the Associated Out-Patient Clinics.

Although medical science has progressed far in the development of methods of treatment for diseases of the eye, it is common knowledge that much preventable blindness exists. Typical cases of eye diseases which may lead to blindness, unless properly cared for, are constantly visiting the various clinics. To discover the proportion of these conditions in the ordinary intake of the clinic, and the care and disposition of these cases by the clinic, a study was made of 5,200 records from five representative eye clinics in New York: Cornell Clinic; Manhattan Eye, Ear and Throat Hospital; Mount Sinai Hospital; New York Eye and Ear Hospital; and New York Post-Graduate Hospital. To allow for sufficient time to have elapsed for the clinic to have disposed satisfactorily of the cases, records of patients who had visited the clinic for the first time at least one year previous to the date of the inquiry were studied. Special attention was given to cases of nineteen selected diseases which may lead to blindness. The list is given toward the close of this article.

Records Are Not Uniform

There is no uniformity in the handling of records and the recording of data in the various clinics. In three, return visits of patients are automatically stamped on their records, and in the other two no notation is made unless the physician happens to record progress notes. In the clinics where automatic stamping is customary, the average number of visits for patients was apparently higher than in the other two. Two dispensaries have central filing systems; medical records are filed in the clinics in the other instances. In none of the five clinics are progress notes consistently recorded. It is customary to enter only the examinations made at the initial visit and medication or treatment; the progress and ultimate disposition of the care are left to the imagination of the research worker.

One hundred and ninety-three, or 3.7 per cent of the 5,200 records fell into this group of selected diseases. There were 34 cases each of keratitis and trachoma, 31 of iritis, 29 of corneal ulcer, 21 of glaucoma, 15 of optic atrophy, 10 of retinitis, six each of purulent conjunctivitis and uveitis, five of choroiditis, one each of ophthalmia and retrobulbar neuritis.

For the reason that diagnoses were often illegible or incomplete, these numbers probably do not represent an accurate cross section of the dispensary intake of these conditions.

Patients Fail to Return to Clinic

The study of these records brings out clearly the failure of patients to attend clinic a sufficient number of times to alleviate the eye conditions or to prevent spread of contagion. One hundred and three of the 193 cases presenting the selected eye conditions are recorded as attending clinic once, 22 attended twice, 38 attended from three to five times, 15 attended from five to ten times, 10 attended from 10 to 20 times, five attended over 20 times. Of the cases with these serious eye conditions which might bring on permanent blindness, 53.4 per cent attended the clinic only one time. Only 15.5 per cent attended more than five times.

The same point is brought out still more forcibly in the instances of certain especially serious diseases. Eighty-three per cent of the cases of purulent conjunctivitis, 80 per cent of the cases of syphilitic retinitis, 75 per cent of the tubercular keratitis, 69 per cent of corneal ulcer attended clinic only once. Eighty-one per cent of the cases of glaucoma made three visits or less. None of the cases of retinitis, optic atrophy or purulent conjunctivitis made more than three visits.

The clinic clearly assumes some responsibility for its patients. That such a large proportion of patients presenting eye conditions which may lead to blindness and the accompanying financial disability does not return for treatment is a stigma of failure on the part of the clinic to assume this responsibility that the administrative and medical authorities can scarcely face with equanimity.

The records showed slight evidence of any attempt

Adv. page 56

to insure proper care to the patient beyond the filling of prescriptions for drugs and glasses, and very little appreciation of the need to protect other members of society from infection. One socially minded physician recorded the fact that in the family of a trachoma patient who attended clinic twice, there were two other children infected with the same disease. The record shows no attempt to have been made to bring the other members of the family under care, or to insure the cure of the original case. There was no evidence of any effort to bring tuberculous cases under proper hygienic conditions. In the syphilitic group laxity was also evident. While it is customary to take Wassermanns it is by no means a universal practice. The following figures show to some extent the failure of the clinics to take advantage of the Wassermann reaction as a diagnostic procedure in the cases of eye conditions which may be caused by syphilis. (Iritis, interstitial keratitis, retinitis, etc.) Of the 79 such cases found in this study, only 36 were given this test, and of these, the results were negative in 17; doubtful in one, positive in 10 and not recorded in eight. Further, the records examined failed to show that the clinics brought the patient who showed a positive reaction under arsphenamin treatment. There was evidence in the record of the provision of proper care for only four out of the ten cases for whom a positive Wassermann report was received.

Some Attempts at Follow-up

The Massachusetts Charitable Eye and Ear Infirmary has demonstrated that it is possible for a dispensary to conduct a systematic follow-up of such cases. At this institution intensive work has been done for classes of phlyctenular keratitis and interstitial keratitis. Not only has the proper medical care been provided, but the cases have been brought under hygienic living conditions and the examination and necessary treatment of other members of the family provided for. A systematic follow-up of other special conditions is also conducted, resulting in the satisfactory control of a large majority of cases until the completion of treatment, and providing a valuable mass of data for research.

The New York State Commission for the Blind has done some pioneer work in the city of New York along these lines through two follow-up workers, one in the Manhattan Eye, Ear and Throat Hospital, and one in the Brooklyn Eye and Ear Hospital. Obviously it is not possible for one individual to handle the follow-up work that should be done in an institution of this size and in neither institution has a systematic follow-up of all cases been installed. However, recognition should be given to the splendid effort which this organization has made.

Recommendations of Ophthalmologists

On the basis of these findings the committee of ophthalmologists has adopted the following recommendations:

"Systematic follow-up to insure continued treatment for at least the following types of cases should be instituted:

Atrophy, optic
Conjunctivitis (purulent)
Choroiditis (tubercular)
Corneal ulcers
Glaucoma
Iritis
Keratitis, interstitial
Keratitis, phlyctenular
Keratitis, tubercular
Neuritis, retrobulbar
Ophthalmia, sympathetic
Papillitis
Papilloedema
Retinitis, diabetic
Retinitis, pigmentosa
Retinitis, syphilitic
Sarcoma of the choroid
Trachoma
Uveitis

"Physicians should be responsible for seeing that the patient is informed of the nature of the trouble and the importance of treatment, and for deciding on what date the patient should return.

"The social service department with such clerical assistance as is necessary should note the name of the patient whose return is desired and through the proper methods endeavor to secure his return at the date specified."

STATISTICS SHOW DECLINE IN DEATH RATE FOR VENEREAL DISEASES*

Figures for industrial policy-holders of the Metropolitan Life Insurance Company during the last four years show a decrease in mortality rates for the venereal diseases. Since 1917 the rate for syphilis, locomotor ataxia and general paralysis of the insane has declined 21 per cent, the figure for 1921 being 13.1 per 100,000 as compared with 16.6 in the earlier year. It is interesting to note that while there was a considerable increase each year from 1911 to 1917, there has been a sharp drop since then. This change is even more significant in view of the fact that reporting is more accurate on death certificates. The decline, therefore, has been accomplished in spite of better reporting. The decline seems to be most decided in the case of syphilis rather than for locomotor ataxia. The figures indicate that the difference between the rates for 1917 and for 1921 is chiefly accounted for by the lowering of the rates in the age period between 25 and 55 years. This improvement may be due to improved methods of treating syphilis as well as the various measures of control established during the war by private agencies acting in cooperation with the government.

VENEREAL DISEASE DATA

It is interesting to note the definite progress that is being made in the accumulation of data on the venereal diseases. The Division of Venereal Diseases of the Bureau of Public Health Service calls attention to the following outstanding facts among the reports received recently:

Of 487 reports received during the quarter ending May 31, 1921, in almost every instance the reports came from sources receiving state aid. Of the total number receiving state aid, sixteen clinics failed to report. Four hundred and nineteen reports were from clinics, and sixty-eight were from detention homes, hospitals for the insane, penal institutions, general hospitals, and some clinics receiving no aid from the state in which they are located.

One state, whose combined report counted as one among the 487 sources, has twelve regular clinics and seventy "cooperative clinics." Each of the cooperative clinics consists of a private physician, specially trained in one of the state clinics, who treats indigent cases free in return for having a minimum of equipment and all drugs furnished by the state. Another state conducts three "treatment centers" on a similar basis; but these are not reporting at present. Both Florida and Michigan have a traveling clinic.

During the quarter, eleven clinics were closed, and fourteen new clinics were established, nine of which have already begun to report.

The Service hopes to receive reports from more than five hundred sources in the near future; and it is urging prompt reporting from every state venereal disease control officer.

*Abstract Service, American Social Hygiene Association.

Adv. page 58

FOREIGN CORRESPONDENCE

SHARP DIFFERENCES OF OPINION MARK ANNUAL CONGRESS OF BRITISH MEDICAL ASSOCIATION

(FROM OUR LONDON CORRESPONDENT.)

AT THE Congress of the British Medical Association which opened on July 21 last at Glasgow with the meeting of the Representatives, the question of the voluntary hospitals was once again fully discussed. The views of those present were extremely conflicting, some holding that the voluntary system should be continued with certain modifications, while others insisted that the system was as dead as Queen Anne and that a system more in conformity with the changed conditions should be thought out and substituted for it.

Mr. Bishop Harman, chairman of the Hospitals Committee, gave it as his opinion that the voluntary hospitals which were started as charitable institutions would go the way of the old educational institutions which had been founded for poor boys but had become the big public schools of the country to which doctors and others now paid handsome fees for their own boys. He thought that the time would come when the state would have made such complete provision for the indigent that the poor would not need to go to the voluntary hospitals, which would then become the place for those who said: "I am willing to pay for my own treatment and maintenance and prefer to have it under private enterprise rather than under state provision."

195 Motions of Policy Before Body

The British Medical Association had to legislate in view of that possibility. There were 195 motions and amendments dealing with hospital policy on the agenda, and the representative body, meeting at 9:30 devoted the whole of the day to their consideration. The discussion verged on the acrimonious and at any rate was distinctly lively. It revealed sharp cleavage of opinion, especially on the dominant question as to whether hospital doctors should be paid a proportion of the money charged by the hospitals in respect of insured or better class patients. With one exception which touched the latter question, the principal motions submitted by the council were carried. They declared *inter alia* that—"The Association recognizes a dual policy as regards the voluntary hospitals: (a) That the purely charitable side should be continued, wherein the whole cost of the main admission of indigent patients is met by the gratuitous contributions received by the hospitals and on whose behalf the services of the honorary medical staffs are given gratuitously; (b) That other patients, who are not indigent, may be received for treatment at voluntary hospitals when adequate treatment cannot be obtained elsewhere, and that for them payments should be received by the hospitals either from the patients themselves or, on their behalf, from the authority or body referring them to the hospital and that on account of their treatment some method of remuneration of the honorary medical staff be arranged."

When he submitted this statement of policy Mr. Bishop Harman said that the profession would gladly continue to give its services "free, gratis and for nothing" to those who were properly entitled to charity. He said: "We are not afraid to speak of charity; it is the finest word in the English language, and we are not going to down it because it is unpopular in certain circles." When the council's report on the whole question was presented for approval, the note of opposition was disclosed, an amendment being put forward declaring it to be unwise to adopt the policy suggested, as it would alter the present status of the medical staff in a manner detrimental to the interest of the profession.

"Aristocracy of Profession" Threatened

Dr. Macfayden in urging the amendment said the profession would suffer politically, economically and in the public estimation if the proposals as a whole came into effect. The medical staff of a voluntary hospital was the aristocracy of the profession in a town, and its members did not want their aristocracy mixed up in money questions. "We do not want the sale of honors in our profession," he said; "we want to maintain the election of staffs purely on the ground of merit and talent and service to the community."

With the money question came the prospect of state interference and lay control. Dr. Rees declared that the voluntary principle of finance in hospitals had broken down. It was inefficient, uneconomical and unfair. Dr. H. S. Souttar said the voluntary system in the old sense was absolutely dead. After all why should they be run entirely on voluntary lines, for "the poor are no longer with us." The amendment was defeated.

Regarding the payment of hospital staffs, Dr. G. E. Haslip, treasurer of the association, said: "We do not call ourselves honorary medical practitioners. We are medical practitioners out for a livelihood." He pointed out that as

Adv. page 60

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the discussion proceeded on the various motions and amendments it demonstrated a deep cleavage of opinion, even among those who supported the formation of hospital staff funds, as to the sources from which these funds were to come. The council recommended that a percentage of all payments whether state aided, rate aided, or private patients' payments, should pass into a fund to be at the disposal of the honorary medical staff. This drew an amendment from Dr. Brackenbury excluding from the motion gratuitous payments by private patients except where these exceeded the cost of maintenance and accommodation. The amendment was carried.

The conflict of opinion was so marked that Mr. Harman withdrew the original motion dealing with the formation of hospital staff funds and put a new proposal in its place to the effect that "the council be instructed to reconsider the terms of the present policy of the association and report what, if any, modifications might be desirable to meet any possible inequities that might arise from its operation." The new proposal was carried on the understanding that Dr. Brackenbury's and other views would be considered by the council. The conference, however, passed the following declaration, recommended by the council:

"Voluntary Administration Advantage to Public"

"In view of the tendency of the state, through local and central authorities, to require the services of the voluntary hospitals, it should be provided that in any arrangement for such services the state should pay a full cost to the hospital so that no portion should be charged to the charitable funds of the hospital, and that the payment so made should include an amount for the remuneration of the honorary medical staff of the hospital." The conference also assented to a declaration that the voluntary method of administration of the voluntary hospitals was to the advantage of the public, medical service and the medical profession and should be retained.

As for the payment of staff a further amended paragraph was passed, the discussion of which led to an examination and re-examination of the arguments for the payment of hospital staffs:—When the board of management of a voluntary hospital enters into a financial arrangement with a public authority, an employer of labor, approved society, insurance company, or under a contributory scheme or otherwise for the reception of patients, such arrangement should be taken to cover the cost of maintenance and treatment and a percentage of all such receipts should be passed into a fund which is at the disposal of the honorary medical staff of that hospital. There followed a lengthy debate upon the definition of a voluntary hospital, some of the definitions proffered were of a quaint and humorous nature.

The definition of the Representative Body was as follows: The association maintains that the essence of the voluntary hospital system is the independent and voluntary management, and that this is not necessarily related to the conditions of service of the medical staff.

In connection with a staff fund the following resolutions have been passed as the result of a conference between representatives of the medical staffs of the following London teaching hospitals: St. Bartholomew's, Guy's, King's College, St. Mary's, Middlesex, St. Thomas', University College, Westminster and the Royal Free.

Resolutions on Staff Fund

1. That under present conditions in the case of patients who contribute towards but pay not more than the whole cost of their maintenance in a voluntary hospital, it is undesirable that any portion of such contribution should be allotted to a staff fund. Adopted with no dissentient.

2. That when the state, a municipal or other public body pays toward the accommodation, maintenance and treatment of a patient or group of patients, in a voluntary hospital, a percentage of such moneys should be allocated to a staff fund. Adopted with Guy's, Middlesex and University College dissenting.

3. That when a special clinic is held by a member of a hospital staff for the treatment of patients sent by the state, a municipal or other public body, the member of the staff taking such a clinic should be adequately paid. Adopted with Guy's dissenting.

It really seems that there is too much talk and too little action with regard to the hospitals of Great Britain. It is notorious that the hospitals in every part of this country are in a deplorable financial situation and this is especially the case with those of London. Moreover, they have been in the dilemma for some time and day by day getting more deeply involved. The profession does not wish for state or municipal control because if either of these alternatives come to pass, its members will lose a great deal of their independence, a possibility which greatly alarms them. On the other hand, some definite steps to relieve the situation must be taken soon. As has been suggested on several occasions in these columns, the most reasonable way out of the difficulty would appear to be the adoption of the pay or partial pay system.

ROTARY CLINIC ACHIEVES RESULTS

Some achievements of the Vancouver (B. C.) Rotary Clinic in its first three years of operation are listed in its third annual report recently issued. The clinic does diagnostic work, provides treatment in the building and on the verandas for incipient cases of tuberculosis, carries on preventive work through a fresh air school and summer camp and sends out much educational propaganda.

Since the opening of the clinic, it has had 5,382 consultations and 2,479 new patients. More than 100 former patients are now earning a living for themselves. The wages of these former patients, the report declares, would pay for the maintenance of several such clinics.

The Vancouver Rotary Clinic, although now operated under a civic grant, was founded by the Rotary Club of the British Columbia city when its attention was called to the need for an "independent separate building for diagnostic purposes, for the treatment of incipient forms of tuberculosis and for a place where all forms of tuber culosis work might be coordinated." With such a clearing house as its goal, the organization pledged $18,000 and in a four-day campaign obtained an additional $60,000 by public subscription. A building was erected, equipped and operated for one year by the Rotary club, after which it was presented to the city of Vancouver. The Rotary Club still provides funds for visiting nurses to aid in the work.

NURSE IS DECORATED BY FRANCE

Miss F. Elisabeth Crowell, R.N., director of nursing service of the Rockefeller Commission for the Prevention of Tuberculosis in France, was recently decorated by President Millerand. Miss Crowell was formerly executive secretary of the Association of Tuberculosis Clinics in the city of New York. The French president pinned the insignia of the Legion of Honor on Miss Crowell at a presidential reception to members of the Commission when it terminated its active work in France.

Adv. page 62

HINTS TO HOSPITAL SUPERINTENDENTS

EDUCATING HOSPITAL TRUSTEES

Hospital superintendents should endeavor to educate their boards of trustees in institutional administration and to this end the following suggestions may be of assistance:

1. One or two of the members of the board of trustees should be appointed each month to make a complete survey of the institution and report their findings at the monthly meeting. When they make this tour of the hospital it would be better if they were unaccompanied by any official. They could consult with an official when the tour was complete.

2. Hospital trustees should be encouraged to read consistently a good hospital magazine.

3. The board of trustees should be given a monthly report of the medical work of the hospital so that they may more fully realize their responsibility as institutional custodians of the health of the community.

4. An excellent plan in use in some institutions is the practice of giving talks at the monthly board meeting on some phase of hospital work. A department head might give a brief survey of his work, or several members of the staff might give two or three minute talks. These would give the trustees a better idea of each phase of the work of the institution, and an opportunity to size up their employees as well.

5. In some hospitals today it is found most valuable to have the monthly board meeting and all committee sessions during the luncheon hour or in the evening at dinner. No doubt meetings associated with luncheons and dinners bring out a better esprit de corps.

Hospital superintendents must remember that trustees are usually not men of the medical profession, and they need an opportunity to acquire information about the institution in order that they may more intelligently deliberate on questions arising in their meetings. Hospital superintendents will therefore do well to consider how best they can educate their boards of trustees along such lines.

THE PAY ENVELOPE BECOMES A DUAL INSPIRATION

The pay envelope at Homeopathic Hospital, Buffalo, in addition to the usual encouragement of currency, contains a printed bit of inspiration to staff and employes monthly.

In the monthly envelope is a "stuffer" containing some pertinent suggestions toward economy and efficiency in the hospital, mimeographed on thin white or yellow paper. These inspirational bits are usually quite brief and touch each month on a new subject: tact, courtesy, quiet, small economies, etc.

One or two of them read as follows:

STOP READ THINK

"HOW NOISY THIS HOSPITAL IS!" This complaint is received more often than you realize. Are you making more noise than is necessary? Banging doors, slamming dishes and utensils, loud talking, laughing and walking? Do *your* part to stop these complaints. *REMEMBER*, this should be a house of *quiet*.

BY THE WAY, are you turning out the lights in your room as you leave it, or the one you saw burning that wasn't needed?

MAKE NEXT MONTH'S SLOGAN "COURTESY"

Genuine courtesy springs from the heart, not from the lips:—

"A little more kindness, and a little less creed,
A little more giving, and a little less greed,
A little more smile, and a little less frown,
A little less kicking the man when he's down,
A little more "WE" and a little less "I"
A little more laugh and a little less cry,
A little more flowers on the pathway of Life
Will prevent many complaints and end much of our strife."

Try it out in your daily routine this coming month. You'll be surprised at the results.

THE UPKEEP OF RATS

Hospitals will find rats very costly guests. The cost of their upkeep mounts steadily as is shown by figures in a recent report of the fire-prevention committee of the Building Managers and Owners Association of New York. The report says:

"A year or so ago some one figured out that it costs us $1.80 per person per year to feed the rats in the United States. Recent figures compiled by a British expert place this cost in the United States at $750,000,000 a year which is a trifle over $7 per person. This is simply for food consumed and destroyed and has nothing whatever to do with the very considerable fire loss they cause."

To render meritorious service and refrain from egotism, to appreciate recognition but scorn applause, to study earnestly and produce conscientiously, to do your work well, as much for the love of the work itself as for your weekly pay, to practice self-denial and grant benevolent consideration to others: these are the principles of progress that push men up the ladder of success.

None need fear that he will not fully share in the progress he promotes for every man's work is a silent and insistent declaration of his true worth.

Adv. page 64

QUERIES AND ANSWERS

USES OF MOTION PICTURE PROJECTORS

To the Editor of THE MODERN HOSPITAL:

To what uses can motion picture projectors be put in hospitals and allied institutions, such as tuberculosis sanatoriums, homes for the aged, etc.—READER.

Motion picture projectors can be used in hospitals or in allied institutions in the following ways:

To assist in the education of medical students in teaching hospitals.

For purposes of education in schools of nursing.

To some extent for the instruction of interns in non-teaching hospitals.

For the entertainment not only of the hospital's ambulatory patients in some lecture room or auditorium, but also of its bed patients.

For educating the general public as to the facilities and services the hospital has to offer.

To stimulate interest in campaigns for recruiting pupil nurses.

To educate and inform the public in fund-raising campaigns, whether for maintenance or construction.

PRESERVING LINOLEUMS

To the Editor of THE MODERN HOSPITAL:

What is the best method for preserving and keeping inlaid linoleums? Although we have a standard grade linoleum on our floors it has not worn particularly well nor does it have a bright and glossy appearance.

HOSPITAL SUPERINTENDENT.

For inlaid linoleums the best preservative treatment is waxing. Before applying the wax, the linoleum should be thoroughly cleaned by scrubbing with warm suds made with mild soap, preferably a vegetable oil soap. After the floor is dry, a good floor wax—liquid is best—should be applied and rubbed in thoroughly. The use of a weighted brush or an electric floor waxer will give a brilliant polish and a smooth surface to which dirt will not adhere. After three or four such waxings, a week or so apart, the wax need not be renewed oftener than once every two or three months. Daily cleaning need consist only of going over the floors with a dry mop.

Varnishing is the best treatment for printed linoleums. The best results are obtained through the use of a waterproof, thoroughly elastic preparation; ordinary cheap varnishes are liable to crack and turn white or yellow after they have been walked upon for some time.

Extreme care should be taken against the use of soap or soap powders containing alkalis, for their repeated use will make your linoleum wear out in a few years. Perhaps that will explain your difficulty. These alkalis eat into the oxidized linseed oil in the linoleum just as they do into the paint or varnish or woodwork, the base of which also is linseed oil.

EXTERMINATING THE COCKROACH

To the Editor of THE MODERN HOSPITAL:

What is the quickest means of exterminating cockroaches? In spite of extreme care, our hospital, which is an old building remodeled, has become infested with these pests. We have tried various prepared sprays and powders and while they have helped they have not freed us entirely from the roaches. SUPERINTENDENT SMALL HOSPITAL.

Several years ago the United States Bureau of Entomology conducted some scientific tests on insecticides, vermicides and other exterminators and some of these studies concerned the extermination of the common roach. As a result of these tests it was found that sodium fluorid was the most rapid killer of roaches of all the many substances tested. Even when diluted down to 18 per cent content, the chemical was almost 100 per cent disastrous. A mixture containing 50 per cent of sodium fluorid ought easily to kill all the roaches about your kitchen and elsewhere in the institutions.

Barium carbonate and mercuric chlorid give effective results. Arsenious oxid and mercury bichlorid should not be used as both are too poisonous to human beings.

SOILED LINEN IN CONTAGIOUS HOSPITALS

To the Editor of THE MODERN HOSPITAL:

What is the approved method for handling soiled linen in contagious disease hospitals? SUPERINTENDENT.

Many hospitals sterilize their linen before washing, or use sterilizing washers. In the latter instance, a separate sorting room is provided where the linen can be placed in the double-headed sterilizing washer, the other end opening into the clean washing room, or a non-sterilizing washer, one with openings on two sides facing into the infected sorting room and one on the clean side. This is perhaps a good plan in very large hospitals, but it is not necessary in smaller institutions. The important item in the laundering of infected linen is the way it is handled during collection and washing. Methods used in a commercial laundry are not satisfactory or safe, but if the washing is done with water at a temperature of 95 degrees or thereabouts, all organisms, except perhaps some spore-bearers, are killed.

WHAT CASES TO ISOLATE

To the Editor of THE MODERN HOSPITAL:

What cases, other than the so-called infectious diseases, should be isolated in general hospitals?

SUPERINTENDENT OF GENERAL HOSPITAL.

Cases of typhoid fever, pulmonary tuberculosis, anterior poliomyelitis, epidemic cerebro-spinal meningitis, contagious skin diseases as impetigo, etc., erysipelas, lethargica encephalitis, septicemia, tonsillitis, venereal diseases, ophthalmia, trachoma, suspects of all kinds, mental cases, drug addicts, alcoholics and cases which are obnoxious owing to odor, appearance, etc.

Adv. page 66

BOOK REVIEWS AND CURRENT HOSPITAL LITERATURE

PERSONAL HYGIENE APPLIED

By Jesse F. Williams, M.D., Associate Professor of Physical Education, Teachers College, Columbia University, New York[1].

"The Art of Fine Living" would be an appropriate subtitle to the volume, "Personal Hygiene Applied," by Dr. Jesse Fiering Williams of Teachers College, Columbia. In presenting his book to students and the public, Dr. Williams—who, by the way, is a professor of physical education—has as his aim the improvement of "the quality of human life" and he does not lose sight of his lofty goal on a single page of his 12mo. work.

Nowadays we possess a lively interest in health matters, Dr. Williams asserts, but oftentimes we make health too important as an end, and thus mar life. It is tremendously important, in his opinion, that we recognize health only in its relation to other values.

This from the standpoint of the hygienist is a new angle. "Health for health's sake" has been the slogan of the majority; now our attention is called to "health for life's sake"—mental, social and moral life as well as mere physical well-being. Indeed, cites Dr. Williams, three of the finest things in life—heroism, creative work and child-bearing—are often injurious to health, but to avoid them is to warp life and to misplace values woefully. The sacrifice of health in personal, selfish and unsocial ways can never receive sanction, he says.

The first five chapters of the book are treated in a vein, more or less philosophic, and we get from them something of the author's enlarged viewpoint of health goals. The rest of the book considers hygiene from its scientific side.

Dr. Williams is both scientific and tolerant in his views, and his leadership is away from superstition, fads and tradition into the realms of science and intelligence.

Physicians, nurses and hospital social workers are frequently called upon to furnish some sound guide to patients, parents and teachers in the way of healthful living. This book will answer that purpose in a broader way than many works of pure hygiene.—M. W.

CLINICAL LABORATORY TECHNIC FOR NURSES

By Anna L. Gibson, R.N., Matron Superintendent, Collis P. Huntington Memorial Hospital, Harvard Medical School, Boston, Mass. Revised Edition.[2]

This book owes its existence to the frequent requests on the part of graduate nurses for a simple comprehensive textbook that will enable them to grasp the principles of clinical laboratory technic.

The purpose is to help nurses have a more intelligent understanding of laboratory work and its relation to nursing, and to fit them for positions as laboratory technicians. The arrangement of the chapters has worked itself out from a series of lessons, hence it is the result of experience and has given most satisfactory results.

The chapter headings are Laboratory Equipment, The Microscope, Urine, Feces, Gastric Contents, Sputum, The Blood, Bacteria, Culture Media, Body Fluids, Milk, Preparation of Tissue.

The volume includes all the information required by a student who aims to become a laboratory technician and is free from the mass of detail that makes many books cumbersome.

Descriptions and definitions are simply and clearly stated, which is a great help to the average student, as "laboratory directions" often bewilder rather than direct. A good grade of paper, clear type and useful illustrations are noticeable features.—C.E.G.

THE AMERICAN POCKET MEDICAL DICTIONARY

Edited by W. A. Newman Dorland, M.D., editor "American Illustrated Medical Dictionary." Twelfth Edition Revised[3].

Saunders' pocket lexicon of medical terms has recently had its twelfth revision, and with the addition of several hundred new terms it is strictly up-to-date. The rapidly increasing vocabulary of medicine and the allied sciences necessitates frequent reference to such a work, and this handy sized volume of limp leather invites the busy practitioner or the student to its constant use. Of course, in an abridged work of the sort, definitions must of necessity be brief, but the editor has succeeded admirably in his purpose to make them concise and to the point. In addition to the ordinary terms of medicine have been included numerous tables of doses and other tabulated material.—M. W.

BOOKS RECEIVED

APPLIED CHEMISTRY. By Fredus N. Peters, Ph.D., Former Instructor in Chemistry, Central High School, Kansas City, Mo.; More Recently Vice-Principal. C. V. Mosby Company, St. Louis, 1922.

SYMPTOMS OF VISCERAL DISEASE. A study of the Vegetative Nervous System in its Relationship to Clinical Medicine. By Francis Marion Pottenger, A. M., M.D., LL.D., F.A.C.P., Medical Director, Pottenger Sanatorium for Diseases of the Lungs and Throat, Monrovia, Cal. Second Edition. With eighty-six text illustrations and ten color plates. C. V. Mosby Company, St. Louis, 1922.

1. W. B. Saunders Company, Philadelphia and London, 1922.
2. Whitcomb & Barrows, Boston.
3. W. B. Saunders Company, Philadelphia and London, 1922.

Adv. page 68